III. Current Services and Service Gaps Analysis

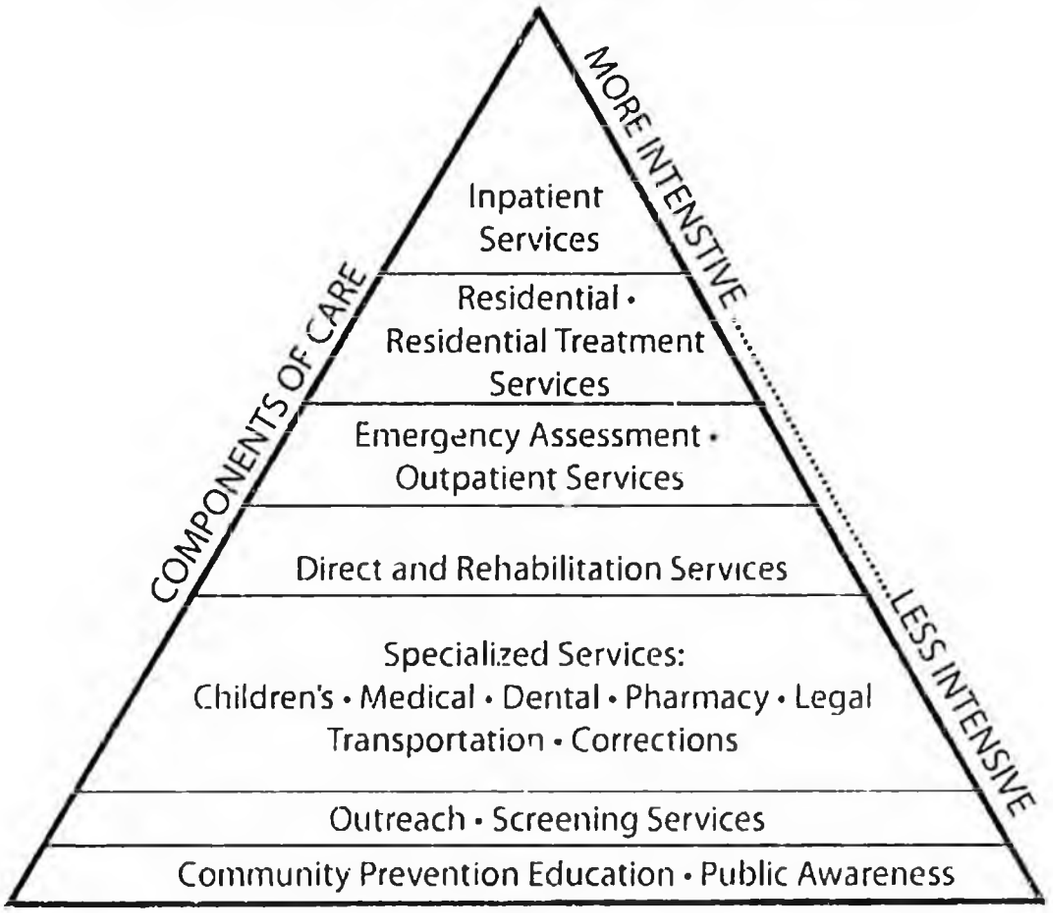
Services for Alaskans experiencing developmental disabilities, alcoholism or other drug addictions, mental or emotional illnesses, and Alzheimer's disease or other dementias were originally shaped and frequently compartmentalized by federal funding availability and federal program requirements. Advocates and program managers have long recognized that service integration is a first step toward higher quality services, increased access to services, and greater cost savings. In addition, many people experience more than one beneficiary disability during the course of their lifetimes. Simplifying and coordinating services for people with multiple cognitive or developmental disabilities is both cost effective and provides better care. Initiatives, discussed in a later section, address gaps in service delivery systems.

Figure 15 — Components of Care for Three or More Beneficiary Groups

The Trust and the Department of Health and Social Services support the components of care illustrated in Figure 15, ranging from prevention at the bottom to acute care at the top for people requiring intensive care. Public education and prevention services, which reach large audiences, are listed at the bottom of the diagram. Services in the middle of the triangle are home and community-based and are used by people requiring a less intensive level of care.

Although economies of scale restrict some services to urban areas, the Plan's vision is that appropriate services would be available when needed across the state. The components of care listed are only those that serve three or more beneficiary groups. These are the same services listed in the Matrix on the following page.

Figure 15
Components of Care for Three or More Beneficiary Groups



Current Services

Table 2 shows the geographic availability of services that are needed by three or more Trust beneficiary groups.

Table 2— Matrix of Current CIMHP Services

Matrix of Current CIMHP Services for Three or More Trust Beneficiary Groups

Service	Level 1: Village	Level 2: Subregional Center or town	Level 3: Regional Center or Small City	Level 4: Urban Center	Level 5: Metropolitan Area
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000 + in immediate community providing services to a larger regional or statewide population	200,000 + in immediate community.
Inpatient services	⊏	⊏	✧	◆	◆
Residential Services	⊏	⊏	•	✧	✧
Emergency/ Assessment / Outpatient Services	•	✧	✧	◆	◆
Direct and Rehabilitation Services	•	✧	✧	✧	✧
Specialized Services					
Children's Services	•	•	✧	✧	✧
Medical services – specialized	⊏	⊏	◆	✧	✧
Dental services – specialized	⊏	⊏	✧	✧	◆
Pharmacy services	•	◆	◆	◆	◆
Legal services	✧	✧	✧	✧	✧
Transportation services – specialized	•	•	✧	✧	✧
Corrections services	⊏	⊏	•	✧	✧
Outreach/Screening	•	•	✧	✧	✧
Community Prevention, Education, Public Awareness	•	•	✧	✧	✧

◆ Available (adequate): the service is widely available and meets most needs

✧ Sometimes available (gaps exist): the service is currently available in many communities of that size but not in all such communities, or is not available to all eligible individuals due to inadequate resources.

• Minimally available (needed): the service is mostly unavailable.

⊏ There is not general agreement that these services are feasible at this level of community.

Service Gaps Analysis

The matrix in Table 2 represents a first effort to analyze those similar services provided by separate service delivery systems to different Trust beneficiary groups. Planning staff (DHSS, The Trust, AMHB, ABADA, GCDSE, ACoA, and the Department of Corrections) developed this matrix by comparing service definitions used by different programs and coming to agreement about common definitional elements and suitable aggregate definitions. Next, based on the common definitions, the group assessed service availability using the Alaska Mental Health Board's Level of Community template. This

assessment was based on data and documents produced by the agencies represented by the planning staff.

Development of the matrix assists in considering collaborative approaches and in determining priorities for service needs. Several observations can be made from the matrix:

- Many commonalities exist among services to beneficiaries, especially in such specialized services as medical, dental and pharmacy services.
- The more specialized the service, the more likely it is to have substantial gaps in delivery. For example, even in Alaska 's metropolitan area (Anchorage), gaps exist in direct and rehabilitation care, the foundation of personal support and recovery: even when a service is available, "gaps" may reflect a lack of capacity to serve all who need that service.
- Access to care and participation in community life may require specialized transportation, a service that is needed across all levels of community.
- The matrix also shows that despite efforts to develop services in regional centers, this strategy has not yet produced a full range of adequate care in those areas.
- Below the regional center level, many gaps exist, both for individualized services and for facility based care.

Some service delivery programs, notably those for people with Alzheimer's disease or similar dementia and for people with developmental disabilities, try to meet each person's particular needs in their own homes. Ideally, this would mean that all services could be made available at each level of community. However, the reality is that resources frequently limit such delivery. Often, providers may not be available in a community, but more commonly, resources do not meet current need. For example, about 1,006 people with developmental disabilities were waiting for services at the end of fiscal year 2006.[40]

The Trust and the Department have targeted development of infrastructure and resources for many of these services.

Continuum of Care Matrices for Trust Beneficiary Groups

Definitions for Levels of Community

LEVELS OF COMMUNITY*					
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
Government	Community or city council, Native Council, incorporated city or unincorporated community.	Incorporated city, may have health powers and may provide health and social services.	Incorporated city or unified municipality, may have health powers and may provide health and social services.	Incorporated, home rule city or unified municipality; may have health powers and may provide health and social services.	Incorporated, home rule city, or unified municipality; may have health powers and may provide health and social services.
Population	25+ in immediate community.	500+ in immediate community; a sub-regional population of at least 1,500.	2,000+ in immediate community, providing services to a regional population of at least 5,000	25,000+ in immediate community providing services to a larger regional or statewide population	200,000+ in immediate community.
Economy	Subsistence, government services (e.g. school)	A developing private sector, some government services; provides some service to surrounding areas.	Regional trade and service center, mixed economy with multiple private and government employers.	Major trade and service center, broad based multi-sector economy.	Principal trade and service center; broad based, multi-sector economy.

Health & Social Services	Community Health Aide, paraprofessional and itinerant services.	Health and social services may be provided by both the private and public sector, community clinic and mid-level provider or MD.	Health care and social service agencies, including both private and government programs; community hospital and physicians.	Multiple providers of health care and other services including both private and government programs; health care specialists; hospitals with full continuum of care.	Level IV plus highly specialized medical and rehabilitation services; specialized hospitals and consulting services.
Access	Usually, more than 60 minutes by year-round ground transportation from a Level II or III community; limited air and/or marine highway access to Level II or III community.	Usually less than 60 minutes by year-round ground transportation from a Level III community; marine highway or daily air access to closest Level III community; airline service to Level I communities in the area.	Daily air service to closest Level IV or V community; airline service to Level I and II communities in the region; road or marine highway access all year.	Daily airline service to Level II, III, IV, and V communities; road or marine highway access all year.	Daily airline service to Level II-IV communities; road or marine highway access all year.
Communities	Too numerous to list, includes Anvik, Eagle, Houston, Ruby, Hydaburg, Wales, Skagway, etc…	Aniak, Craig, Delta Junction, Tok, Emmonak, Fort Yukon, Galena, Haines, Hoonah, Hooper Bay, King Cove, King Salmon/Naknek, Nenana, McGrath, Metlakatla, Mt Village,St. Mary's, Sand Point, Togiak, Unalaska, Unalakleet, Glennallen/ Copper Center	Barrow, Bethel, Dillingham, Homer, Kenai/Soldotna, Ketchikan, Kodiak, Kotzebue, Nome, Palmer/Wasilla, Sitka, Cordova, Petersburg, Wrangell, Valdez, Seward	Fairbanks, Juneau	Anchorage

**Levels of Community Care is a document created by the Alaska Mental Health Board (rev.8/93).*

Continuum of Care Matrix for Alaskans with Behavioral Health Disorders (Mental Illness, Alcoholism, Drug Addictions)

LEVELS OF COMMUNITY *					
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
I. Community Prevention / Education	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**	**I. Community Prevention/Education**
	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help	a. Advocacy/self-help
	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention	b. Prevention and intervention
	c. Community education	c. Community education	c. Community education	c. Community education	c. Community education
	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support	d. Peer, Consumer, and Client Support
	Services	Services	Services	Services	Services
	General Availability?	**General Availability?**	**General Availability?**	**General Availability?**	**General Availability?**
	None	Very limited	Limited capacity	Some capacity	Greatest capacity

II. Behavioral Health Services (a-g)					
a. Outreach	a. Outreach **General Availability?** None	a. Outreach **General Availability?** Very Limited	a. Outreach **General Availability?** Limited capacity	a. Outreach **General Availability?** Some capacity	a. Outreach **General Availability?** Greatest capacity
b. Emergency Services	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very limited	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very good capacity	b. Emergency Services i. 24 hour telephone screening, assessment, triage ii. Crisis Intervention & Stabilization **General Availability?** Very good capacity
c. Assessment	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral	c. Assessment i. screening ii evaluation/referral

	General Availability? Very limited	General Availability? Good capability	General Availability? Good capability	General Availability? Excellent capability	General Availability? Excellent capability
d. Outpatient (Clinic-Based) Services	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** None	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Limited capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Good capacity	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Excellent capability	d. Outpatient Services i. Screening ii. Face-to-Face assessment & triage (SA;MH; TBI) iii Treatment Planning iv. Counseling (1:1; Group) **General Availability?** Excellent capability
e. Rehabilitation & Recovery Services	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based	e. Rehabilitation & Recovery Services i. Case Management ii. Skill Development iii. Day Treatment iv. School/home-based

	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** None	services v. Supported Living vi. Individualized services vii. Intensive outpatien. services **General Availability?** Very limited	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Good capacity	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Excellent capacity	services v. Supported Living vi. Individualized services vii. Intensive outpatient services **General Availability?** Excellent capacity
f. Medical Services	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** None	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Limited	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity	f. Medical Services i. Psychiatric Assessment ii. Pharmacological Management iii. Medical Co-morbidity **General Availability?** Good capacity

Detoxification Services	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** None	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Very limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Very Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Limited	g. Detoxification i. social detox ii. outpatient detox iii. medical detox **General Availability?** Limited
III. Residential Services					
a. Children Services	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care	a. Day Treatment b. Foster Homes c. Therapeutic Group Homes d. Emergency Stabilization & Assessment e. Residential Treatment f. Secure Locked Residential Care

	General Availability? None	**General Availability?** Very limited	**General Availability?** Limited Capacity	**General Availability?** Good capacity	**General Availability?** Good capacity
b. Adult Services	a. Crisis Respite b. Residential Treatment **General Availability?** None	a. Crisis Respite b. Residential Treatment **General Availability?** None	a. Crisis Respite b. Residential Treatment **General Availability?**	a. Crisis Respite b. Residential Treatment **General Availability?**	a. Crisis Respite b. Residential Treatment **General Availability?**
IV. Inpatient Services (Acute)	a. Acute Psychiatric Care b. DET / DES **General Availability?** None	a. Acute Psychiatric Care b. DET / DES **General Availability?** None	a. Acute Psychiatric Care b. DET / DES **General Availability?** Very limited	a. Acute Psychiatric Care b. DET / DES **General Availability?** Limited	a. Acute Psychiatric Care b. DET / DES **General Availability?** Good

Definitions for Continuum of Care Matrix for Alaskans with behavioral health disorders (mental illness, alcoholism, drug addictions)

Community Prevention/Education: Community interventions and education that ward off the initial onset or risk of a substance use or mental disorder or emotional or behavioral problem, including prevention of co-occurring substance use and mental health disorder. Community prevention/education examples include peer/consumer and client support services; community education; advocacy/self-help; and prevention.

Outreach: Facilitate entry into treatment or meeting the individual within their community, job, home or school setting to engage in treatment or support services for either a substance use or mental disorder or for those individuals experiencing co-occurring mental health and substance use disorders. **(Agency Defined).**

Emergency Services: are provided in a crisis situation during an acute episode of a substance use, mental, emotional or behavioral disorder. Emergency services are intended to reduce the symptoms of the disorder, prevent harm to the recipient or others; prevent further relapse or deterioration of the recipient's condition; or to stabilize the recipient. Inpatient Medical Detox is also included in this section. This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Detoxification Services: Detoxification is a process involving multiple procedures for alleviating the short-term symptoms of withdrawal from drug dependence. The immediate goals of detoxification are 1) to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free; 2) to provide withdrawal that is humane and protects the client's dignity; and 3) prepares the client for ongoing treatment of alcohol or drug dependence.

Social Detox: This is a model of detoxification that requires no medication, and allows the client to withdraw from abused chemicals in a safe environment.

Outpatient Detox : The client is at minimal risk from severe withdrawal, which requires moderate levels of medication and monitoring.

Medical Detox: This level of detoxification provides the highest level of monitoring. Placement criteria are defined by the presence of high risk factors for complicated withdrawal: high risk biomedical complications, psychiatric or behavioral complications.

Assessment: A face-to-face, computer assisted, or telephone interview with the person served to collect information related to his or her history and needs, preferences, strengths, and abilities in order to determine the diagnosis, appropriate services, and /or referral for services to address substance use and or mental disorders. The type of assessment is determined by the level of entry into services and the qualified staff delivering the service: Intake Assessment, Drug/Alcohol Assessment, Psychiatric Assessment, Psychological Assessment, Neuro-Psychological Testing and Evaluation.

Outpatient (Clinic-Based) Services: Refers to a range of facility based behavioral health services that can include assessment, individual, family, and group therapy. These services are designed to treat substance use disorders, mental illness, behavioral maladaption, or other problems: to remove, modify, or retard existing symptoms, attenuate or reverse disturbed patterns of behavior and promote positive recovery, rehabilitation, and personality growth and development.
Note: Screening differs from assessment in the following ways:

Screening is a process for evaluating the possible presence of a particular problem; and,

Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

Rehabilitation and Recovery Services: Refers to a range of services that are available to clients who meet criteria based on levels of functioning in multiple spheres. Services can include a functional assessment, case management, individual/family/group skill development, and recipient support services. A functional assessment assists the client in identifying areas of need in developing a treatment plan. Case management services assist the recipient in accessing and coordinating needed services, such as medical, substance use, psychiatric, and behavioral health care. Skill development services help the recipient develop or improve specific self-care skills, self-direction, communication and social interaction skills necessary for successful community adjustment and interaction with persons in the recipient's home, school, work, or community environment. Recovery is a treatment philosophy that provides the framework of service delivery. A recovery model offers hope that the restoration of a meaningful life is possible and achievable.

Medical Services: Refers to a range of behavioral health services that are delivered by trained medical staff, and can include psychiatric assessment and pharmacological management, and medical co-morbidity.

Residential Services: Is a licensed 24 hour facility (not licensed as a hospital) which offers behavioral health services which include treatment for substance use disorders; settings range from structured facilities, resembling psychiatric hospitals or drug/alcohol treatment facilities, to those that function as group homes or halfway houses; therapeutic foster care and foster care, family teaching homes, crisis beds, therapeutic group homes, staff-secure crisis/respite group homes, residential case managements specialized drug/alcohol, evaluation/treatment and specialized vocational rehabilitation.

Inpatient Services: Inpatient hospitalization is the most restrictive type of care in the continuum of behavioral health services; it focuses on ameliorating the risk of danger to self or others in those circumstances in which dangerous behavior is associated with substance use or mental disorder. Services include facility-based crisis respite, community hospitals, Designated Evaluation and Treatment (DET) beds, and the Alaska Psychiatric Institute (API).

Continuum of Care Matrix for Alaskans with Developmental Disabilities

	LEVELS OF COMMUNITY*				
Characteristics	**Level I: Frontier/Village**	**Level II: Sub-Regional Center or Town**	**Level III: Regional Center or Small City**	**Level IV: Urban Center**	**Level V: Metropolitan Area**
I. Information and Referral	Telephonic assistance in completing eligibility applications information about and referral to services described below	Telephonic assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below	assistance in completing eligibility applications information about and referral to services described below
II. Direct Services	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications	Case Management/Care Coordination Respite Specialized Medical Equipment Environmental Modifications

	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response Legal Services	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response Legal Services	Day Habilitation Supported Employment / Subsistence Activities Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response	Day Habilitation Supported Employment Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response	Day Habilitation Supported Employment Vocational Rehabilitation Transportation Coordinated transportation system Educational services Infant Learning Preschool K-12 Chore Services Intensive Active Treatment Crisis Response

			Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services	Medical Dental Pharmaceutical Recreation Legal Services
III. **Residential Services**	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home	In-home Support Shared Care Family Habilitation Supported Living Group Home

Definitions for Continuum of Care Matrix for Alaskans with Developmental Disabilities

I. Information and Referral is a service whereby individuals and families can learn about the generic and specialized types of services and supports available in Alaska. Assistance in acquiring and completing eligibility paperwork can be provided, and referrals can be made to agencies offering the types of services an individual or family is seeking. This service is provided by a variety of agencies, including Infant Learning and Early Intervention Programs, school districts, Head Start, Public Health Centers, the Department of Health & Social Services, and various non-profit agencies that provide services to individuals and families.

II. Direct Services described below are available to eligible individuals depending on availability of funding.

Case Management/Care Coordination assists persons in gaining access to needed medical, social, educational and other services regardless of the funding source for the services to which access is gained. Case management links persons with complex personal circumstances to appropriate services and insures coordination of those services. This service may include referral services, routine monitoring and support, and/or review and revision of the habilitation plan.

Respite provides relief to caregivers from the everyday stress of caring for an individual who experiences a disability. Respite care can be provided in a variety of settings. Providers are trained in first aid, CPR, behavior and physical management, and information specific to the recipient's needs. Respite care cannot be used for regular childcare or adult day care except for short-term emergency situations.

Specialized Medical Equipment and Supplies are devices, controls or appliances that enable an individual to increase their ability to perform activities of daily living, or to perceive, control or communicate with the environment in which the individual lives. They are also supplies and equipment necessary for the proper functioning of the above medical equipment.

Environmental Modifications are physical adaptations to an individual's home, which are necessary to ensure the health, welfare and safety of the recipient.

Day Habilitation services assist with acquisition, retention or improvement in self-help, socialization and adaptive skills, and may include pre-vocational training or subsistence activities. These services take place in a nonresidential setting, separate from the home in which the individual lives.

Supported Employment services are provided at a work site in which individuals without disabilities are employed. They include the adaptations, supervision and training needed by individual unlikely to obtain competitive employment at or above the minimum wage. Supported employment is for individuals who need intensive, ongoing support, supervision and training to perform in a work setting. Supported employment may include subsistence activities.

Vocational Rehabilitation services include job counseling, referral, on-the-job training, tests and tools to evaluate an individual's talents, short-term job try-out, job search and placement services, interpreter, reading and tutoring services. In some cases additional services may be covered.

Transportation services enable an individual and necessary escort to gain access to home and community-based waiver services or other community services and resources. Transportation may be provided as part of a coordinated transportation system, with public buses, accessible, door-to-door vans and/or taxi service. In smaller communities this service may be provided through social service agencies.

Educational Services are provided to eligible children birth to 3 through the Infant Learning Program, from 3-5 through the school districts and/or Head Start and from 5-22 through the school districts.

Infant Learning Program services include developmental screening, evaluation, and information about the child's strengths and needs, home visits to help the family or caregivers guide their children in learning new skills, physical, occupation or speech therapy, specialized equipment and resources, and assistance in getting other specialized services and care.

Preschool Special Education services are provided to children ages three through five in order to meet their individual needs identified either through the Infant Learning Program or designed by an interdisciplinary team working through an Alaskan school district. These services are developmentally appropriate and include needed physical, occupational and/or speech therapy, and needed adaptive equipment. Services are designed to prepare children for an inclusive kindergarten placement.

Special Education and Related Services encompass the provision of a free and appropriate education to children aged 3-21 who experience a disability and require specialized instruction in the least restrictive environment. Certified special educators and aides provide a range of services including adaptive physical education, individualized help with all school subjects and classes. Public schools are charged with transitioning students to adult life beginning at age 16.The overall goal of special education is to prepare students for independent living and employment.

Chore Services include regular cleaning and heavy household chores within an individual's residence, snow shoveling to provide safe access and egress, and other services necessary to maintain a clean, sanitary and safe environment in the individual's residence.

Intensive Active Treatment are time-limited specific treatments or therapies to address a family problem or a personal, social, behavioral, mental, or substance abuse disorder in order to maintain or improve effective functioning of an individual. These are designed and provided by a professional or paraprofessional working under a professional.

Crisis Response is offered as short-term assistance to people with developmental disabilities and their families. The purpose is to stabilize circumstances in order to keep the family unit intact, prevent an out-of-home placement, or to maximize an individual's ability to function independently in a difficult situation by providing immediate but limited relief. Examples include ground and/or air transportation and lodging, emergency car repairs needed to maintain employment, and emergency utility expenses if there is an immediate health and safety issue.

Medical services include screening, assessment, diagnosis, and treatment. Specialist and sub-specialist care is available in a limited number of larger communities.

Dental services include preventive and restorative care.

Pharmaceutical services provide access to prescribed medications, nutritional supplements, and durable medical supplies and equipment.

Recreational services are frequently offered by parks and recreation programs. Therapeutic and inclusive recreation and the loan of adaptive recreational equipment are also available.

Legal advocacy services for people with disabilities are available. The state's protection and advocacy program provides training in self-advocacy, disability rights, and special education, assists individuals and family members in advocating for their rights, provides legal representation when problems cannot be resolved by other means, and investigates complaints of abuse, neglect and denial of rights. Private attorneys may also provide representation for a fee.

III. Residential Services

In-home Support services are designed to help individuals overcome or cope with functional limitations.

Shared Care is an arrangement whereby an individual spends more than 50% of the time in the home of an unpaid primary caregiver, and the remainder of the time in an assisted living home.

Family Habilitation services are provided to individuals who live more than 50% of the time in an assisted living home or foster home, receiving care from a paid caregiver who is not a member of the individual's family. This residential arrangement does not require the natural family to give up custody or parental rights. Families and the individual may help choose the Family Habilitation home.

Group Homes are provided to individuals 18 years of age or older who live in an assisted living home. Habilitation plans frequently include goals designed to develop relationships and skills that lead toward increased independence.

Supported Living services are provided to individuals 18 years of age or older in the recipient's private residence by a caregiver who does not reside in that residence. Habilitation plans identify the various levels of training and supervision needed by adults moving into or living in settings that maximize their independence.

Continuum of Care Matrix for Older Alaskans and Alaskans with Alzheimer's Disease and Related Dementias

Characteristics	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
I. Services for Individuals with Alzheimer's Disease and Related Dementias					
a. Outreach & Education	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, some trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Kenai. Literature, audio/video resources, some trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Aging and Disability Resource Center in Juneau . Literature, audio/video resources, trainings available through Alzheimer's Resource or Geriatric Ed Centers	Information and referral available statewide through SeniorCare toll-free number. Literature, audio/video resources, trainings available through Alzheimer's Resource or Geriatric Ed Centers. Statewide conferences.
b. Assessment	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.	Assessment – targeted, personal service.

c. Medical	Community Health Aides	Health Clinics, Physician's Assistants, Public Health Nurses	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, some small communities have hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals	Health Clinics, Physician's Assistants, Public Health Nurses, Nurse Practitioners, physicians, hospitals
d. Pharmaceutical	Prescription medications available primarily through village-based IHS clinics or dispensaries.	Prescription medications available primarily through IHS clinics and some private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.	Prescription medications available through IHS clinics, hospitals, private pharmacies, physicians and nurse practitioners.
e. Home and Community Based Services					
ii. Personal care attendant	Personal care attendant – very limited, not available in many villages due to workforce shortage	Personal care attendant – targeted, personal, very limited, not available in many towns due to workforce shortage	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce	Personal care attendant – targeted personal, dependent on available workforce
iii. Chore services	Chore services – very limited, not available in most villages due to workforce shortage	Chore services – limited, dependent on workforce availability	Chore services – dependent on workforce availability	Chore services – dependent on workforce availability	Chore services – dependent on workforce availability

iv. Respite	Respite – very limited, not available in most villages	Respite – limited, not available in all towns	Respite – dependent on workforce availability	Respite – dependent on workforce availability	Respite – dependent on workforce availability
v. Adult da, programs for individuals with ADRD. 15 programs across state, two which coordinate with community mental health centers for assessment, referral and medication management.	not available	not available	Adult day programs – limited availability	Adult day programs	Adult day programs
vi. Meals – congregate and home-delivered	Congregate meals very limited, not available in most villages/home delivered meals not available	Congregate meals limited, not available in all towns/ home delivered meals not available	Meals – congregate and home-delivered, one or both available in some communities	Meals – congregate and home-delivered available	Meals – congregate and home-delivered available
viii. Environmental modifications	Environmental modifications – rarely available due to lack of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications – dependent on availability of local contractors	Environmental modifications	Environmental modifications
ix. Specialized medical equipment	Specialized medical equipment – limited availability	Specialized medical equipment – limited availability	Specialized medical equipment	Specialized medical equipment	Specialized medical equipment
f. Family Caregiver Support	Family caregiver support – very limited, not available in most villages	Family caregiver support – limited, not available in all	Family caregiver support – dependent on workforce	Family caregiver support – dependent on workforce	Family caregiver support – dependent on workforce

		towns.	availability	availability	availability
g. Legal Service (AoA funded through Alaska Legal Services	Phone and internet assistance available	Phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available	Legal Service – in person and phone and internet assistance available
h. Residential Care					
i. Assisted Living Homes	Not available	Not available	Assisted Living Homes – limited availability	Assisted Living Homes	Assisted Living Homes
ii. Pioneers Homes	Not available	Not available	Pioneers Homes – Ketchikan , Palmer, Sitka	Pioneers Homes – Fairbanks and Juneau	Pioneers Home - Anchorage
iii. Nursing Homes	Not available	Not available	Nursing Homes – limited availability	Nursing Homes	Nursing Homes
II. Specialized Behavioral Health Services for Seniors					
a. Mental Health	Not available	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Mental Health for Seniors – limited assessment and referral	Not available
b. Chemical Dependency	Not available	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency – limited assessment and referral	Chemical Dependency Treatment – Inpatient elders program

Definitions for Continuum of Care Matrix for Alaskans with Alzheimer's Disease and Related Dementias

Outreach, Education, Information and Referral:

This category of service provides for outreach, education, information and referral of issues related to ADRD for individuals and their caregivers. This is accomplished through the Senior Centers, the Aging and Disability Resource Centers (provided through regional independent living centers), State SeniorCare Office, and State Care Coordination and Education grants. State grant funds from The Alaska Mental Health Trust Authority (AMHTA), the U.S. Administration on Aging and State of Alaska general funds are used to fund projects offered through private non-profits, tribal and government entities.

Assessment: Assessments are completed under the Medicaid Waiver Program, the Medicaid Personal Care Attendant Program, the Medicaid Long Term Care Program and grant funds from the MHTA and the State of Alaska. These assessments are used to access services and to assist in developing a plan of care for the individual. This service is provided by private non-profits, for profit, tribal and government entities.

Medical Services: This includes any medical treatment for individuals with ADRD by health care professionals or paraprofessionals: i.e., Community Health Aides (CHA's), Certified Nursing Assistants, Registered Nurses (including Public Health Nurses), Physicians Assistants, Nurse Practitioners, and Physicians. Treatment is provided in patients' homes, in health clinics, private provider offices, hospitals and nursing homes.

Pharmacy Services: This includes medications for both physical and mental health needs of seniors. The Medicaid Personal Care Assistance program provides medication management for those who qualify with physical needs. State and federal funds are provided on a limited basis for this service through an Anchorage Senior Center and Mental Health Trust Authority funded grant in Southeast.

Care Coordination: This service makes available an "expert" who is available to navigate the system of care a senior receives through the Waiver or other services. The Care Coordinator works with the senior and her Caregivers to establish a Plan of Care and helps assure that services are delivered adequately to their client. These services are provided by private non-profits, for profit, and tribal entities.

Personal Care Attendants: Personal Care Services are designed to assist seniors in need of assistance with Activities of Daily Living (e.g. bathing, eating etc.) in their own homes. This service provided through Medicaid can be utilized in two distinct ways: Agency

Based services allow for a certified provider to manage the hiring and supervision of a Personal Care Attendant for a senior while Consumer Directed PCA allows for that attendant to be hired and supervised by the senior or their legal representative receiving the services with minimal assistance from an agency.

Chore Services: These are housekeeping and other services in a senior's own home. This program is both a Medicaid Waiver and grant program with funding from the state of Alaska and the U.S. Administration on Aging. Providers of all types offer these services.

Respite Services: Relief to a primary Caregiver in order to reduce caregiver stress is the primary purpose of this service. This service provided under the Medicaid Waiver, U.S. Administration on Aging - National Family Caregiver Program and state grant programs. Providers of all types offer these services.

Adult Day Services: Adult day Programs offer facility based programs, which provide recreational, health and social opportunities for seniors who are frail or experience ADRD. These programs are funded through State of Alaska funds and the Medicaid Waiver programs.

Congregate and Home Delivered Meals: These programs offer one third of the recommended daily allowances (RDA) for adults. Congregate meals are provided in senior centers and schools throughout the state. Home Delivered meals are provided for those seniors unable to easily leave their homes. These programs are provided by private non-profits, for profit, tribal and government entities through the Medicaid Waiver, U.S. Administration on Aging and State of Alaska funds.

Assisted Transportation: Assisted Transportation services are those, which take a senior from their home to appointments and back with door-to-door assistance. Transportation services are provided through the U.S. Administration on Aging, State of Alaska grant funds and the Medicaid Waiver programs through private non-profits, for profit, tribal and government entities. These services include assisted and unassisted rides.

Environmental Modifications: Refers to converting or adapting the environment to make tasks easier, reduce accidents, and support independent living for frail seniors and/or individuals with disabilities. Examples of home modification include: lever door handles that operate easily with a push; handrails on both sides of staircase and outside steps; ramps for accessible entry and exit; walk-in shower; grab bars in the shower, by the toilet, and by the tub.

Specialized Medical Equipment and Supplies: Specialized equipment and supplies include devices, controls, or appliances specified in the plan of care which enable clients to increase their ability to perform activities of daily living, or to perceive, control or communicate with their environment.

Family Caregiver Programs: These programs offer a wide range of services for family caregivers of seniors with the focus solely on the caregiver's needs. The U.S. Administration on Aging funds programs, which are designed to support Caregivers of seniors recognizing their unique role in the continuum of care. Grants are made to private non-profits to execute these programs.

Legal Service: Legal services for seniors consist primarily of guardianships and other minor legal problems. Through funding from the U.S. Administration on Aging and the State of Alaska, a provision of legal services is provided for seniors and their caregivers through Alaska Legal Services Corporation.

Assisted Living Homes: Assisted Living homes provide 24-hour care to seniors in a non-institutional setting outside a senior's home.Assisted Living homes are operated by private non-profits, for profit, and tribal entities using funds from the Medicaid Waiver Program and the State of Alaska grant funds. These homes provide twenty-four hour care for seniors and others in non-institutional settings often in or near the seniors community.

Pioneers' Homes: Located in six communities (Sitka, Ketchikan, Juneau, Anchorage, Palmer and Fairbanks) the Alaska Pioneers' Homes provide up to 600 beds of assisted living services for seniors in Alaska. Open to any senior over 65 years of age these homes are funded through the Medicaid Waiver and State of Alaska funds and operated by the Department of Health and Social Services. They have developed a specialty in serving those people who experience ADRD as well as other frail seniors. They have a Registered Nurse on site 24 hours a day and provide a centralized pharmacy, which includes a high level of medication oversight.

Nursing Homes: Skilled Nursing Facilities provide intensive services for those at the highest level of care. Funded through Medicaid they offer both short and long-term placements for senior who require significant nursing interventions each day. In many cases, through Medicare funding these facilities provide for rehabilitation services for senior returning to their homes from acute hospitalizations.

IV. Examples of Current Initiatives, Projects and Activities That Fill Service Gaps

One aim of *Moving Forward* and its related initiatives is to provide decision makers with appropriate data regarding issues that impact Trust beneficiaries. To the extent data is available or can be developed through better data collection and analysis, progress is measured for these efforts. A key strategy has been to work with partners on projects. Successful partnerships expand and enhance the resources of the Department of Health and Social Services and The Trust and further the goal of shared and integrated approaches to bettering the lives of Trust beneficiaries. Initiative efforts are largely directed toward system change. Following are examples of current initiatives, projects and activities that, in addition to the extensive day-to-day activities of the Department and The Trust, work to create system change and target improved services for Trust beneficiaries.

System Strategies

Over the last few years, The Trust and DHSS have focused efforts in six areas: prevention, integration of services, infrastructure development, workforce development, employment, and public awareness. The emphasis has been to alter the systems that provide services, and organize them in more effective and efficient ways that better meet needs, while promising cost savings in the future. Increasing public acceptance of Trust beneficiaries through education is a long-term effort to improve their lives.

Below are some examples of projects that focus on changing systems through prevention, integration, infrastructure development, workforce development, employment, and public awareness.

Prevention

The federal Substance Abuse and Mental Health Services Administration defines prevention as:

"A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors."

Mental health and substance abuse prevention activities for children and youth focus on building emotional resiliency and adding positive influences and protective factors to children's lives. Prevention includes not only interventions that occur before a problem occurs, but also interventions that prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children's emotional and developmental disorders from becoming more severe.

Community-based Suicide Prevention and Rural Human Services

In 2004 (the most current year with official national data), Alaska had the highest suicide rate in the United States. Suicide was the 11th leading cause of death in the United States for all ages and third among the young. During that same period in Alaska, suicide was the fifth leading cause of death for all ages and second for those under age 50. The distribution of suicide by ethnicity shows a greater proportion of Alaska Natives taking their own life than the Caucasian or "other" racial categories. Although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. And, the majority of suicides are occurring among our young people ages 20-29 years of age.[20, 41]

To better address this reality, DHSS established two programs aimed at rural Alaska and at suicide prevention and early intervention. The Community-based Suicide Prevention program provides small rural Alaska communities with the resources to take ownership of community-driven solutions to high numbers of suicides, attempted suicides, depression and alcohol use. In fiscal year 2007, over 25 communities received a comprehensive behavioral health prevention grant, with a focus on suicide prevention. Recognizing that suicide is often associated with overall mental health and alcohol and other drug use, the department requested that communities look at suicide from a holistic perspective. The goal is to integrate with other programming to reduce drug and alcohol use, increase connectedness and resiliency and to better recognize the signs of suicide.

In an effort to increase the number of trained human service paraprofessionals in our most rural and remote communities, the Rural Human Services Systems (RHSS) project, a partnership between the DHSS Division of Behavioral Health and the University of Alaska Fairbanks, Rural Human Services program, trains, hires, develops and mentors local providers in communities across Alaska. The goal of "a counselor in every village" has not yet been reached, but the number of students who have completed their Rural Human Services certification and have returned to their villages as paraprofessional counselors grows each year. Through RHSS funding, 15 rural agencies receive funding to train and employ counselors in more than 100 villages across the state. These individuals serve as a community resource, a first responder, a referral source and often, the only available resource in a community dealing with suicide, substance abuse, domestic violence, child abuse, delinquent youth and more. The Department of Health and Social Services requested and received an increment of $550,000 in fiscal year 2007 to add ten additional human service counselors statewide. With this additional funding, the Division of Behavioral Health was able to increase funding to some existing programs to serve more villages, and add two new programs through Copper River Native Association and Cook Inlet Tribal Council, Inc.

Comprehensive Fetal Alcohol Syndrome Project

Fetal alcohol spectrum disorders (FASD) are one of the most common causes of mental retardation, and the only cause that is entirely preventable. FASD refers to all those conditions caused by prenatal exposure to alcohol, including fetal alcohol syndrome (FAS). FAS is a medical diagnosis defined by the presence of specific growth and nervous system abnormalities and other factors. Receiving an early, comprehensive diagnosis that looks at growth deficiencies, facial dysmorphology, central nervous system

functionality and maternal history of alcohol abuse provides a complete picture of the level of disability, the impaired functionality and the overall interventions and accommodations that will benefit the individual. This is the first and most important intervention—from a comprehensive diagnosis, a clear case plan can be implemented and service delivery needs can be better coordinated.

FASD is found in all races and all socio-economic groups – wherever women drink alcohol, FASD exists. With the right diagnosis, support and understanding, many individuals with FASD can live happy and full lives.

Alaska's Comprehensive Fetal Alcohol Syndrome Project is an example of an effort to prevent a developmental disability, to improve services for individuals with an alcohol-related disability and to enhance alcohol treatment services for women at risk of drinking alcohol during pregnancy. With state and federal funds, the Alaska FAS Project developed community-based teams that diagnose and refer children for services, developed a multimedia public education campaign to raise awareness about the danger of drinking alcohol during pregnancy, and improved training for all service providers in Alaska to better understand and serve affected individuals and their families. Alaska's FAS Project has enhanced the state's surveillance of alcohol-related births; thereby improving the state's data related to FAS prevalence rates.

- In fiscal year 2007, the Division of Behavioral Health continued funding for 20 community-based grants awarded to local nonprofit organizations across Alaska to provide services related to individuals, families and communities impacted by FASD. These grants focus on FASD prevention, training and educational services, improved services for individuals affected by FASD, diagnostic services, and treatment services for women at risk for giving birth to a child affected by prenatal exposure to alcohol.
- Since March of 1999, approximately 1,000 diagnoses have been completed by 13 Diagnostic Teams from Fairbanks to Ketchikan, providing earlier and more comprehensive assessments for those children, youth and adults who were pre-natally exposed to alcohol, causing permanent learning, behavioral, and neuro-developmental disabilities. Through early and comprehensive diagnosis, children and youth have more opportunities for services that will increase their quality of life and their ability to be healthy, productive adults.
- Two curricula were developed to give Alaska service providers (including educators, mental health clinicians, health care providers, and correctional officers) current, consistent and scientifically-based information about the affects of alcohol on a developing fetus, the impact of alcohol on the central nervous system, and the resulting disabilities. Over 50 Alaskans, representing Alaska geographically, ethnically and across various disciplines, have been trained and certified to provide training with these two curricula.
- In December 2006 the DHSS received a five-year Medicaid Waiver Demonstration Project to improve services to young Alaskans ages 14-21 with co-occurring diagnoses of SED and a FASD. This Demonstration Project will allow

Alaska to begin developing "practice to research" service delivery approaches that will improve the long-term outcomes for youth with these diagnoses.

Medicaid Disease Management Program

Based on input from the National Governors Association Chronic Disease Policy Academy, a steering committee of top Alaska Department of Health and Social Services policy makers has been convened to direct the development of a Medicaid Disease Management (DM) Program. The DM program is a system aimed at coordinated health care interventions and communications for populations with chronic conditions. DM supports the provider-patient relationship and plan of care and emphasizes prevention utilizing evidence-based practice guidelines and patient empowerment strategies. A critical component of DM is evaluating strategies designed to optimize both clinical and economic outcomes.

The steering committee has worked with DHSS staff to analyze Medicaid claims data, identify target populations, and begin designing a DM program. The committee will develop a request for inclusion in the Department's FY 2009 budget. Within the next fiscal year, the steering committee will seek approval from the Center for Medicare and Medicaid Services for their program, and will develop a communications plan for engaging Medicaid clients and providers, develop an evaluation plan, and issue a Request for Proposals to secure a DM vendor.

The Strategic Prevention Framework

The Division of Behavioral Health, Prevention & Early Intervention Services has begun using Strategic Planning Framework from the SAMHSA Center for Substance Abuse Prevention. The purpose of the framework is to build the capacity of states, Native organizations, and communities to decrease substance use and abuse, promote mental health, and reduce disability, co-morbidity and relapse related to mental and substance use conditions.

The Strategic Prevention Framework (SPF) utilizes the following five-step process:

Assessment: *Profile population needs, resources, and readiness to address the problems and gaps in service delivery.* Communities must accurately assess their substance abuse-related problems using epidemiological data provided by the State as well as other regional and local data.

Capacity: *Mobilize and/or build capacity to address needs.* Engagement of key stakeholders at the State and community levels is critical to plan and implement successful prevention activities that will be sustained over time.

Planning: *Develop a comprehensive Strategic Plan.* Communities must develop a strategic plan that articulates not only a vision for the prevention activities, but

also strategies for organizing and implementing prevention efforts in their community

Implementation: *Implement evidence-based prevention policies, programs and policies and infrastructure development activities.* Similarly, local stakeholders will use the findings of their needs assessments to guide selection and implementation of policies, programs and practices proven to be effective in research settings and communities.

Evaluation: *Monitor process, evaluate effectiveness, sustain effective programs/activities, and improve or replace those that fail.* Ongoing monitoring and evaluation are essential to determine if the outcomes desired are achieved and to assess program effectiveness an l service delivery quality.

Integration

Behavioral Health Integration Project (BHIP)
(http://hss.state.ak.us/dbh/system_redesign/service_delivery_system_headlines.htm)

The DHSS Division of Behavioral Health has been integrating the two former DHSS systems that provided community mental health and community drug and alcohol treatment into a single behavioral health system. In addition the BHIP project has worked extensively to develop co-occurring capability (services for individuals with both mental health and substance use disorders) throughout the behavioral health service system. This project, broad in scope, aims to transform the Alaska behavioral health services system. The goal of the BHIP is to develop a behavioral health services system that is welcoming, accessible, integrated, comprehensive and continuous, at a client, consumer, clinician, program and system level.

More recently, the focus of the BHIP project has been to finalize the integration of regulations for the system of care. After a significant effort to obtain input from providers and other stakeholders, the DBH is current engaged in the internal process of regulations development that will culminate in adoption of regulations to govern the Behavioral Health Service system.

Early Childhood Comprehensive Systems (ECCS) Early Childhood Mental Health Cross-Systems Workgroup
(http://www.hss.state.ak.us/ocs/childplan/default.htm)

Over the last year the ECCS (Early Childhood Comprehensive Systems) Early Childhood Mental Health Cross-Systems Workgroup developed recommendations to improve accessibility to appropriate, high quality mental health services for young children birth to five years of age. They are beginning the process of translating these recommendations into regulatory and policy changes.

The ECCS Workgroup is developing a viable model for mental health consultation for professionals who work with young children in Alaska. They are piloting a model over the next year which includes billing for Medicaid Administrative reimbursement. This will help build the number of Alaska's mental health practitioners who are more skilled in working with early childhood mental health issues and interventions. The ECCS Workgroup supported a two day "early childhood mental health training" for a cohort of mental health clinicians, early interventionists and child protection staff from across the state. The mental health clinicians and early interventionists will continue to participate in a "learning network" via monthly conference calls with a consultant with expertise in this area. This effort will continue and be expanded to more professionals over the coming year.

Health Care Strategies Planning Council

(http://www.hss.state.ak.us/hspc/)

A new Health Care Strategies Planning Council was appointed by Governor Palin to develop a statewide plan to effectively address the issues of access to, and cost and quality of, health care for Alaskans. The intent is that the council's development of a health care action plan should serve to educate all Alaskans about the myriad of public policy choices regarding health care issues and engage both governmental agencies and the private sector in finding solutions to these problems.

The council has been directed to prepare and submit to the governor and the Legislature, by January 1, 2008, a health care action plan which includes the following: (1) a description of the current health care system in Alaska; (2) an inventory and analysis of all existing private and public health care plans, reports, and initiatives in Alaska; (3) short-term and long-term statewide strategic plans designed to improve health care access, cost, and quality within the next ten years; and (4) performance measures and accountability mechanisms to provide policy makers with tools to assess the success of the strategic plans over time. In addition, the council will convene a health care conference to take public testimony on the issues of health care access, cost, and quality, and to serve as a forum to educate all Alaskans on health care issues.

The commissioner of the Department of Health and Social Services is chairing the council and the Department is providing administrative support.

Infrastructure Development

Affordable Housing Focus Area

http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Affordable%20Appropriate%20Housing

Trust beneficiaries have many unmet housing needs; therefore the Alaska Mental Health Trust Authority has identified affordable housing as a priority area for funding and advocacy. Safe, decent, affordable, accessible and appropriate housing is often the key for Trust beneficiaries in maintaining a healthy lifestyle and participating in rehabilitation

and recovery activities. The statewide shortage of affordable, safe, accessible, and appropriate housing disproportionately affects Trust beneficiaries due to the challenges associated with disabling conditions and the lack of opportunities for economic advancement. Some beneficiaries require long term supportive living situations or accommodations to meet special needs and others simply require a subsidy for a period of time to afford permanent, stable housing.

The following strategies comprise the Affordable Housing focus area's approach to increasing the number of safe, affordable housing options available to Trust beneficiaries:

- Policy advocacy for new funding resources (i.e. an affordable housing trust in Alaska, inclusion of supported housing in mainstream affordable housing, etc.)
- Adaptation of successful models and existing housing options in Alaska: increasing targeted support services for intensive needs populations, adapting successful models to support alcoholics in recovery, inclusion of special needs housing in community developments, etc.
- Increasing capital resources for supportive housing
- Increasing options for housing preservation, i.e. maintaining successfully housed Trust beneficiaries in homes as long as possible through temporary mortgage assistance, increasing options for financial literacy, etc.
- Increasing the availability of long term care supports and community based services for those beneficiaries who are at risk of institutionalization.
- Increasing the availability of technical assistance through the state's Department of Health and Social Services for development and maintenance of safe, affordable housing at the community level.

The Trust is working with several housing development groups, including Tlingit and Haida Housing Authority and Cook Inlet Housing Authority, to determine the best method for supporting beneficiaries in affordable housing. Successful projects have been supported through the Kenai Peninsula Housing Initiatives, Valley Residential Services and Anchorage Housing Initiatives.

The Bridge Home program is an example of an early success for The Trust's Affordable Housing focus area. This "housing first" program provides housing subsidies and supports to individuals with severe mental illness who have a history of repeated episodes of institutionalization. Modeled on successful supportive housing projects in Hawaii, Connecticut and New York, the Bridge Home Program assists clients to stabilize in their own homes and eventually become eligible for HUD Section 8 vouchers and a semi-independent lifestyle. As a result of the Bridge Home program, clients have decreased their rates of incarceration. Of the 31 Bridge Home clients with a history of incarceration during the pre-program period, 29 (94%) decreased their rates of incarceration and 2 (6%) increased. The clients who had no history of arrests during the pre-program period were also not arrested during the program.

Alaska Council on Homelessness
(http://www.ahfc.state.ak.us/homeless/homeless.cfm)

The Alaska Council on the Homeless was initially established in April 2004 to develop a statewide action plan addressing homelessness in Alaska. The plan, *Keeping Alaskans Out of the Cold,* was completed and submitted in October 2005. Included in its recommendations was the appointment of a steering committee to assist the governor and the legislature to develop an affordable housing trust. The steering committee completed its work in 2006 and the current council has recommended that the Alaska Housing Trust Fund be created within the Alaska Housing Finance Corporation (AHFC) under statute.

The Alaska Council on Homelessness consists of members appointed by the governor. The council will assist with development of the Alaska Housing Trust Fund; annually evaluate housing needs and priorities to establish a statewide homeless action plan and recommend to the AHFC Board of Directors the allocation of money in the fund to implement the plan; monitor and review implementation of the statewide homeless action plan; and annually report to the governor on how state resources, in addition to the fund, may be used to end homelessness.

Alaska Housing Trust
http://www.akhousingtrust.org/index.cfm?section=about&page=overview

Under its Affordable Housing focus area, the Alaska Mental Health Trust Authority has been engaged in advocating and planning an Alaska Housing Trust. In May and June 2007, major funding partners, The Trust and Rasmuson Foundation, granted $1 million each to pilot the project. The Municipality of Anchorage also plans to allocate portions of its federal grant resources to leverage these funds in the pilot program. The housing focus area workgroup will play a major role in developing supported housing projects for this trial run.

Alaska Policy Academy on Homelessness
(http://www.hrsa.gov/homeless/State/ak.htm)

The goal of the Alaska Policy Academy on Homelessness is to enable Alaskans to live in appropriate and affordable housing as close to their community of choice as possible by: (1) promoting locally delivered collaborative family-centered services; (2) increasing collaboration and coordination to end homelessness; (3) increasing safe and affordable housing stock; and (4) ensuring integrated planning for homelessness in Alaska.

Bring the Kids Home
(http://www.mhtrust.org/index.cfm?fa=documents_meet-search&doctype=Focus%20Areas%20-%20Bring%20the%20Kids%20Home)

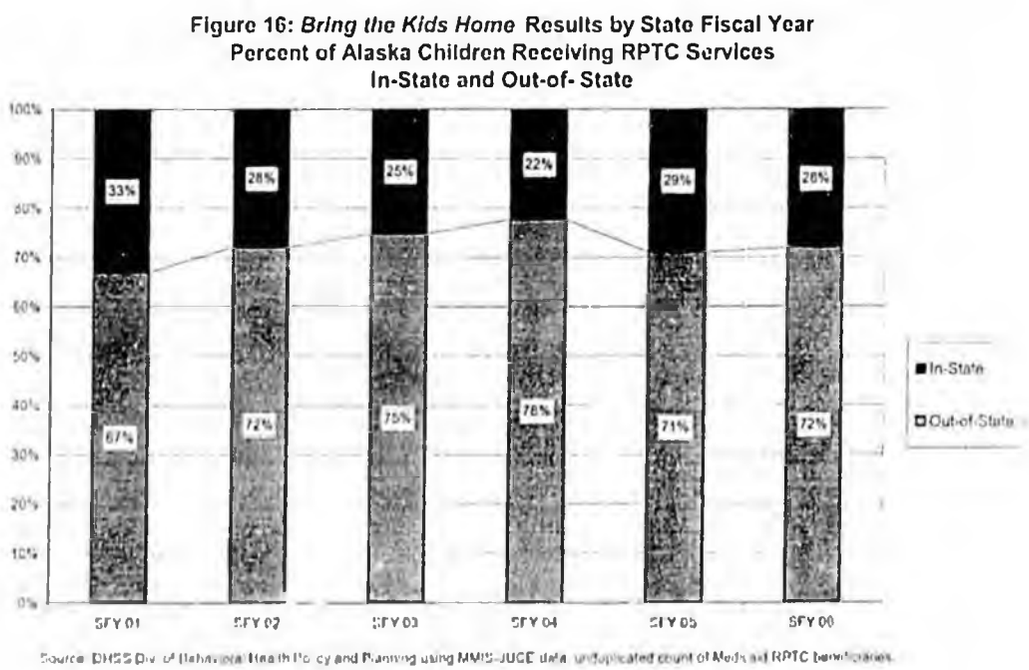
During the period of 1998 – 2004, the children's behavioral health system in Alaska became increasingly reliant on institutional care - Residential Psychiatric Treatment

Center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800%. At any given time, approximately 350-400 children were being served in out of state placements. Alaska Native children represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.

The Department of Health and Social Services, in collaboration with the Alaska Mental Health Trust Authority initiated the "Bring the Kids Home" (BTKH) Initiative in 2004, to return children being served in out-of state facilities back to in-state residential or community-based care. The initiative intends to reinvest funding now going to out-of-state care to in-state services and develops the capacity to serve children closer to home. With financial support, this initiative will focus on successfully building upon the existing infrastructure to treat youth in their community, region and state.

The scope of this project requires that four levels of the system of care must be addressed concurrently: community, regional, in-state, and out-of-state care. Further, there are issues that are applicable to the overall system of care, i.e. policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding, expansion of facilities and infrastructure, and expansion of services.

Figure 16: Bring the Kids Home Results by State Fiscal Year -Percent of Alaska Children Receiving RPTC Services In-State and Out-of- State



Source: DHSS Div. of Behavioral Health Policy and Planning using MMIS-JUCE data, unduplicated count of Medicaid RPTC beneficiaries.

Dental Care Access

The Trust and DHSS are committed to improving access to dental care for all Trust beneficiaries. The Trust is participating with the Alaska Dental Access Coalition (ADAC) which is focusing on policy areas of workforce, finance and reimbursement, service availability and access and prevention of oral diseases. The coalition serves in an advisory capacity to the DHSS Oral Health Program supported by a grant from CDC.

The ADAC is a multi-agency coalition with broad support and participation on dental access issues. The ADAC is chaired jointly by The Trust and the Rasmuson Foundation, and staffed by DHSS. After successfully advocating for the new adult dental Medicaid benefit (implemented April 1, 2007), the coalition is committed to tracking the progress of the adult dental Medicaid services program and preparing to advocate for the renewal of the program in FY2009 when the enabling legislation has a "sunset" provision. Additional work is proceeding in all of the focus areas outlined in the ADAC activities.

Disability Justice – Justice for Persons with Disabilities Focus Area

Beneficiaries of the Alaska Mental Health Trust are at increased risk of involvement with the criminal justice system both as defendants and as victims. Limitations and deficiencies in the community emergency response, treatment, and support systems make criminal justice intervention the default emergency response to the conditions and resulting actions of many Trust beneficiaries. The Trust's Justice for Persons with Disabilities Initiative began in April 2004. A collaborative group, including The Trust, advisory boards, state and local government agencies, the court system, law enforcement, consumers, advocacy groups, community behavioral health providers, and others, have developed and are implementing the following several strategies to address this issue:

- increase training for criminal justice personnel;
- sustain and expand therapeutic court models and practices;
- improve continuity of care for beneficiaries involved with the criminal justice system;
- increase capacity to meet the needs of beneficiary offenders with cognitive impairments;
- develop mechanisms to address the needs of Trust beneficiaries who are victims;
- develop community-based alternatives to incarceration for beneficiaries;
- develop a range of housing options to provide for varying needs of beneficiaries involved at different stages of criminal justice system; and
- evaluation of the initiative's impact to improve justice for beneficiaries.

Examples of Justice for Persons with Disabilities Focus Area Projects:

Judicial and legal training. A collaborative effort among The Trust, Alaska Court System, Alaska Bar Association, and the Anchorage Bar Association to provide education and training to assist judges, lawyers, and other legal professionals understand and more effectively handle cases involving persons with mental

disabilities. A six session continuing legal education (CLE) curriculum has been developed and implemented covering a variety of topics from an overview of mental health disorders to effectively communicating with persons who experience a mental disorders.

Crisis Intervention Team (CIT) training. A 40 hour training in which law enforcement personnel are educated about mental illnesses and other disabilities, medications, suicide and crisis intervention, active listening skills, de-escalation techniques, empathy, and respect. The CIT training recognizes the need for a specialized response to those who experience mental illness and other disabilities. It is a community based partnership between consumers, law enforcement, NAMI (National Alliance on Mental Illness), and community treatment providers. All have joined together to recognize the common goals of safety, service, and understanding. Currently, CIT teams exist with the Anchorage and Fairbanks police departments.

Therapeutic court principles and models. Therapeutic court principles and models focus on appropriately diverting Trust beneficiaries with mental disabilities charged with misdemeanor offenses from incarceration and into appropriate community treatment and services, preventing further contacts with the criminal justice system. There are therapeutic mental health and drug courts operating in communities throughout the State (Anchorage, Bethel, Juneau, Ketchikan, and Palmer).

Discharge planning from corrections into the community. The Department of Corrections is working with state, federal and community partners to coordinate and develop a pilot re-entry transitional services model for Trust beneficiaries being released from correctional institutions to the community. The *APIC transitional model* (Assess, Plan, Identify, and Coordinate), cited as a best-practice in the 2004 President's *New Freedom Commission Report on Mental Health*, is being adapted to meet Alaska's needs. The goal of the APIC re-entry pilot is to connect Trust beneficiaries with services prior to release and to provide intensive supports upon their initial release, to both increase their chances of success in the community and to reduce the potential for re-incarceration. The communities targeted, but not confirmed for this pilot include: Anchorage, Palmer and Wasilla, Fairbanks, and Juneau.

Victimization. Trust beneficiaries are at increased risk because they are more vulnerable to financial, physical, and sexual victimization and exploitation. However, the number of Trust beneficiaries who are victims of crime each year is unknown because victimization of persons with disabilities too often goes unrecognized and unreported or, if reported, not pursued because of the perceived limitations or lack of credibility of the victim. The University of Alaska's Center for Human Development with funding from The Trust is gathering in-state data on these issues to define the scope and extent of the problem.

Division of Juvenile Justice System Improvement Initiative

For the past several years through its system improvement efforts, the Division of Juvenile Justice (DJJ) has enhanced the services provided to juvenile offenders and families who are also Trust beneficiaries. Strategies put in place by DJJ to address youth with behavioral health issues range from services that are community-based, to facility detention and treatment services, to re-entry or aftercare services. These include, for example, non-secure shelters for youth with immediate behavioral health problems and alternatives to detention such as electronic monitoring and community detention. Strategies also include therapeutic services with the addition of mental health clinicians in several facilities and substance abuse counselor certification for field and facility staff across the state. Aggression Replacement Training, proven to be effective in increasing pro-social behaviors and reducing recidivism for youthful offenders, has been implemented statewide. In addition, DJJ is partnering with the Court and other stakeholders to develop a pilot mental health court in Fairbanks. Upcoming activities include the integration of the statewide DJJ facility suicide prevention policy into a statewide policy for residential providers; and the integration of three new mental health clinician positions into DJJ core services along with ensuring DJJ clinical practices are consistent statewide and comport with existing Alaska protocols supported by the Department of Health and Social Services.

The Healthy Body, Healthy Brain Campaign

The Healthy Body, Healthy Brain Campaign is an education and public awareness effort based on recent research indicating that many cases of Alzheimer's Disease and Related Disorders (ADRD) can be prevented by a healthy lifestyle that includes physical activity, good nutrition, weight management, regular socializing, and intellectual tasks such as puzzles and games. An ADRD-preventive lifestyle has much in common with the habits already associated with avoiding other chronic diseases such as diabetes, heart disease and cancer. However, people often fear the mental losses of ADRD more than they fear a heart attack, an amputation, or a round of chemotherapy. As a motivator, the prospect of developing ADRD may be particularly effective.

This prevention and health promotion project will use evidence-based social marketing techniques to reach middle-aged and older adults (directly and through workplaces, senior centers, and other organizations with which they're connected) to maximize the awareness of the public as well as health care and social services professionals of the importance and the effectiveness of a healthy, balanced lifestyle in preventing ADRD. The Healthy Body, Healthy Brain Campaign, funded by The Trust, is to be initiated in FY 08 by the Alaska Commission on Aging and the Division of Public Health.

Performance Management System Project

(http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm)

The DHSS Division of Behavioral Health "Performance Management System" is developing a continuous quality improvement process to guide policy and decision-

making for improving the behavioral health of Alaskans. The Performance Management System has three broad components: the service delivery system, broad population planning, and DBH management indicators.

In the pubic service delivery system, the performance measures address whether the services are of high quality; whether the behavioral health system is efficient, productive, and effective; and whether services produce the desired impact on the quality of life of consumers. To support behavioral health planning for the broader population, the project will address the following questions: (1) are Alaskans who need services getting them, and able to get them conveniently; (2) do Alaskans with behavioral health disorders live with a high quality of life; and (3) are efforts taking place to prevent or lessen problems that result in consumers needing services. The DBH Management Indicators component will address performance indicators useful for the management of the service delivery system, including accountability and documented outcomes to provide transparency in the use of public funds.

These performance measures feed into a continuous quality improvement process to inform and improve the delivery of effective, high quality services. Provider organizations may use the DBH performance measures and indicators for planning and evaluating performance improvement activities; for soliciting new funding; or for reallocating resources.

Traumatic Brain Injury Project

The incidence rate of identified Traumatic Brain Injuries (TBIs) in Alaska is 28% higher than the national rate. Alaska's Traumatic Brain Injury Project is focusing on the cognitive, emotional, and behavioral manifestations of traumatic brain injury. In partnership with The Trust, the Department is developing infrastructure to provide for culturally competent treatment and rehabilitation services specific to TBI survivors who experience cognitive, emotional, and behavioral manifestations as a result of head trauma. The Alaska Screening Tool screens all admissions into the public behavioral health system for possible TBI. The project has also sponsored numerous training events to assist the behavioral health system to identify TBI, make referrals, and provide basic services to TBI survivors, and has set up a management information system to eventually track the course of those interventions. The State was also recognized in 2006 for system innovation and included in a Neurobehavioral Handbook in 2007 by the National Association of Head Injury Administrators (http://www.nashia.org/)for these accomplishments. Regardless of these accomplishments, the need for specialized services in Alaska remains high.

The Alaska Brain Injury Network Inc. (www.alaskabraininjury.net) serves as the TBI Advisory Board as well as an information and referral source for Alaskans with brain injuries needs. ABIN works with the Alaska Mental Health Trust Authority and the Department of Health and Social Services to recommend and implement culturally competent and statewide brain injury services.

Trust Beneficiary Projects

Trust beneficiaries and their families are growing increasingly interested in accessing services that are provided by fellow consumers/clients and family members. Such services can create a sense of empowerment and promote recovery, and consumer choice often enhances service quality and sustainability. Trust beneficiary projects can be very cost effective and meaningful to participants. Consumers, or the 'end users of services', have been key to innovations in the state's delivery system by conceptualizing, managing, and improving programs by and for themselves.

The Trust's initiative for beneficiary projects is a method to assist beneficiaries in developing and improving services, while informing the social services field of promising practices in this area. The initiative's goals are:

- ensuring that Trust beneficiary initiated and managed activities are safe, effective, and sustainable;
- providing a viable avenue for organized advocacy that is rooted in community needs and addresses existing service gaps; and
- providing a technical assistance entity to support Trust beneficiary initiatives in data collection, analysis and training activities.

Workforce Development

Trained, experienced professionals are essential to providing the specialized care needed by people with cognitive or developmental disabilities and their families. Barriers to recruitment and retention in Alaska include workers' stress, isolation, low pay, limited benefits, burnout and turnover. Adequate pay, training, and supervision assure better quality care and a more stable service delivery system. In order to provide appropriate services to Trust beneficiaries, an adequate and competent workforce must be recruited, trained, and retained.

Workforce Development Focus Area

The Trust, in collaboration with the Alaska Department of Health and Social Services, other state agencies, the University of Alaska, advisory boards, service providers and Trust beneficiaries and their families, are working to develop a prioritized plan for workforce development for behavioral health and other beneficiary service provider areas. In 2006 and 2007, workgroups on recruitment, retention, and training and education developed action plans for the upcoming fiscal year.

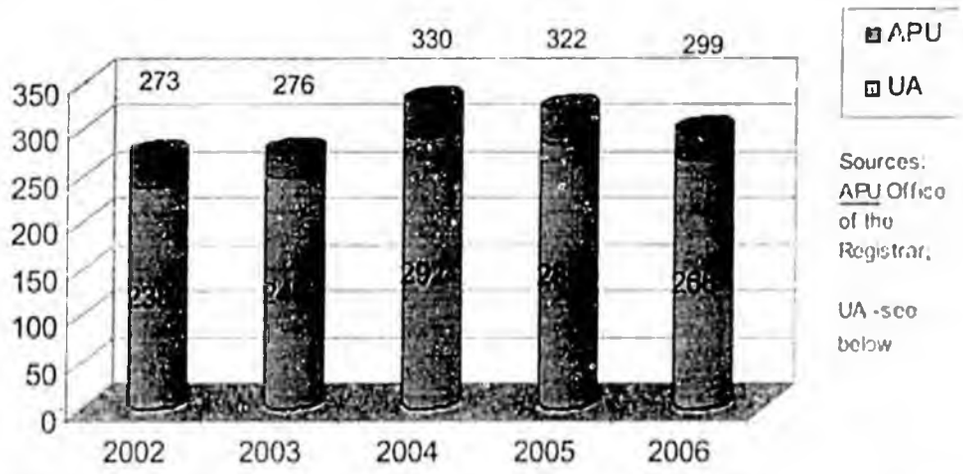
Some examples of proposed activities to increase recruitment, retention, and training for professionals serving Trust beneficiaries include: 1) implement a grow-your-own initiative focused on youth including activities such as job shadowing and behavioral health career clubs, 2) develop marketing strategies within Alaska for beneficiary area service careers in order to recruit broader, non-traditional populations (e.g., Alaska Natives, seniors, retired persons, and persons with disability), 3) provide technical

assistance to and track the progress of 6-10 service providers interested in increasing retention efforts, 4) create a regional training collaborative that provides community-based training that complements other education and training efforts in the state. In addition to generating strategies, the plans assign responsibility for implementing and funding the strategies and for measuring the results.

In addition, DHSS and The Trust are working with University of Alaska and tribal organizations to develop certification standards for behavioral health aides, in order to boost competent and accessible care in rural Alaska communities.

Figure WD-1: Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities

Figure WD-1
Behavioral Health Program Degrees and Certificates Awarded at Alaska's Universities

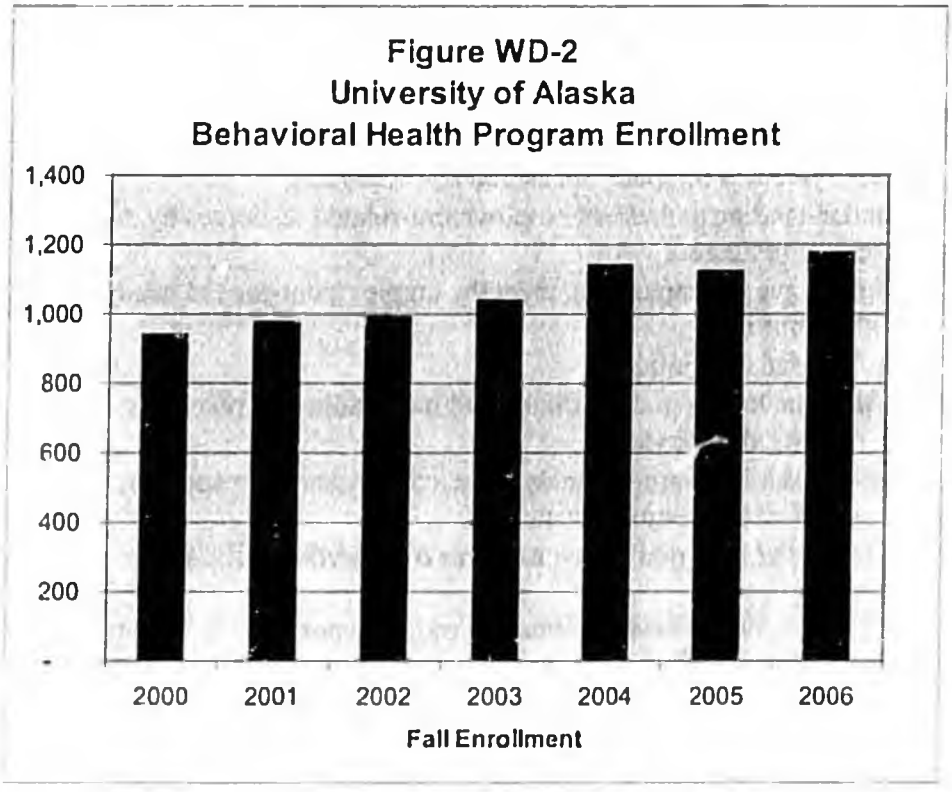


Degrees and certificates included in this data. University of Alaska: Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social Work; BA/BS Psychology; MS - Clinical Psychology, Counseling Psychology. Alaska Pacific University: Counseling Psychology, Human Services, Psychology.

UA Source: UA Information Systems: Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning (http://www.alaska.edu/swoir/)

Alaska Pacific University: www.alaskapacific.edu

Figure WD-2: Enrollment in Behavioral Health Programs at University of Alaska



Source: Information provided by MAUs via UA Information Systems: Banner SI reporting extracts. Prepared by Statewide Institutional Research and Planning. (http://www.alaska.edu/swoir/)

Degrees and certificates included in this data. Certificate - Developmental Disabilities, Disability Services, Human Service Technology, Rural Human Services; AAS - Developmental Disabilities, Disability Services, Human Services; BA - Community and Change, Human Services, Social Work; BA/BS Psychology; MS - Clinical Psychology, Counseling Psychology.

Employment

Moving Forward's goal for economic security includes work opportunities for Trust beneficiaries. Being employed is a common experience that is not always shared by Trust beneficiaries. Employment enhances an individual's self respect and reduces public assistance. For many Trust beneficiaries the goal of employment may be reachable only through the assistance of others.

Alaska Works Initiative

www.alaskaworksinitiative.org

The Alaska Works Initiative is a statewide, federally-funded initiative comprised of a variety of stakeholders who are working to implement the following vision: *Alaskans*

who experience disabilities are employed at a rate as close as possible to that of the general population. Over the next four years, initiative partners will continue to implement the following eight goals:

- Work expectations and incentives are built into programs and services for people with disabilities.
- Success in employment is regularly measured and analyzed.
- Awareness, understanding and use of employment-related resources by Alaskans with disabilities are increased.
- Service providers have the capacity to meet the employment-related needs of Alaskans with disabilities
- Resources are blended and braided.
- A variety of funds including under-utilized and non-traditional resources, are being used to fund needed services.
- Job seekers with disabilities are routinely connected to needed resources, including the workforce investment system.
- Services and resources are coordinated as a part of everyday activities.

As of December 31, 2006, 1,495 individuals were served, of whom 640 or 42.8 percent secured full or part time employment.

In October 2006, the Governor's Council on Disabilities and Special Education received a three-year research and demonstration grant from the federal Office of Disability Employment Policy to increase the number of Alaskans with disabilities who are self-employed. Project goals are to:

- Update and expand resource mapping and needs assessments to identify strengths and limitations of existing resources and ascertain training, technical assistance and policy needs.
- Develop, test, evaluate and disseminate a customized self-employment model at the one-stop job centers in Anchorage, Fairbanks and southeast Alaska.
- Establish a business incubator program
- Modify and/or develop policy that facilitates permanent, systemic change that results in increased numbers of Alaskans with disabilities becoming self-employed.

It is anticipated that the following outcomes will be achieved:

- System wide assessment and identification of self-employment improvement opportunities via resource mapping (see Goal 1 above)
- Piloting and demonstration of two self-employment models (customized self-employment partnerships and business incubator) for 30 self-employed persons with disabilities (see Goal 2 and 3 above)
- Utilizing lessons learned from the pilots, development and implementation of longer term policy and training strategies to enhance Alaska's workforce system's

capacity to successfully serve people with and without disabilities so they can become successfully self-employed (see Goal 4)

Family Centered Services

DHSS's Family Centered Services project for individuals receiving Public Assistance focuses on solving personal and environmental barriers to employment and self-reliance by using a proven, national "customized employment" model. This approach is designed to increase employment options for individuals with significant barriers to employment, such as Trust beneficiaries.

The Division of Public Assistance, working closely with partner agencies including the Division of Behavioral Heath, Office of Children's Service, Division of Juvenile Justice, Division of Vocational rehabilitation and local community partners in Fairbanks and Mat-Su communities, have seen good outcomes through the use of these service techniques. Through the collaboration of the service providers and coordinated case management efforts, families have engaged in activities that have moved them towards self-sufficiency and improved quality of life.

The Division of Public Assistance anticipates expanding the family centric approach to all service areas in the state gradually over the next two to three years.

Public Awareness

The Trust, DHSS and beneficiary boards are committed to reducing the stigma associated with mental health problems, substance use disorders, developmental disabilities, age related dementias and brain injury. Efforts to educate the public will decrease this barrier to necessary care and treatment. Public education to reduce stigma also makes it easier for Trust beneficiaries to participate in community life. Learning about the prevalence of disabling conditions and the availability and effectiveness of treatment can also positively impact public policy.

Trust Coordinated Communications Campaign

Stereotypes about mental illness, addictive diseases, developmental disabilities or dementia make it harder to find work, housing and meaningful social contacts. Stigma can dissuade people from seeking care when they need it. *Moving Forward's* goal is to reduce the stigma associated with mental illness, alcohol abuse, developmental disabilities, and age related dementia. This goal is central to the Coordinated Communications Campaign, an initiative of The Trust and its advisory boards, to reduce the stigma of beneficiary disabilities and to emphasize the concept that treatment and services work. The Coordinated Communications Campaign is multi-media, including newspaper ads, posters, TV ads, movie theater ads, trading cards and radio ads.

V. Emerging Issues/Trends

The timeframe for this *Comprehensive Integrated Mental Health Plan, Moving Forward*, is 2006-2011. During that time period, it is likely that changes in leadership and policies at both the national and state levels will impact the lives of Trust beneficiaries in ways that cannot yet be quantified. More work will be done on these issues as details become clear.

Access to Primary Care for Medicare Patients

Patients in some parts of Alaska report disturbing levels of difficulty in finding primary care providers willing to see Medicare patients. Many seniors have been terminated from care by their long-standing family physicians. Doctors say that Medicare's reimbursement rates cover less than 50% of their costs of care. After a Congressional hearing held by Senator Lisa Murkowski in Anchorage in early 2007, a resolution (SJR 3) passed by the 2007 Alaska Legislature urged Congress to order a comprehensive rewrite of the Medicare reimbursement formulas.

Access to primary care affects all Trust beneficiary groups. There are a number of dual eligibles (Medicaid and Medicare) among the developmentally disabled population, and they are experiencing the same shortage of providers.

Alaska Health Information Exchange (HIE)

The State of Alaska Department of Health and Social Services *Alaska Medical Assistance Program (Medicaid Program)* is collaborating with public and private providers throughout the state to develop a more efficient and cost effective system for communication in healthcare delivery. The goal of the initiative is to coordinate a statewide health information exchange that will improve access to clinical information by both providers and patients.

The intended outcomes of the HIE pilot project are:

- *To ensure timely access to pertinent patient information* – Providers and consumers will have access to complete patient histories in real-time, facil.. ng decision support, prompt treatment, and administrative efficiencies.
- *To improve health outcomes through enhanced monitoring and reporting* – Detailed, comprehensive reports can be generated through connected databases for the purposes of quality outcomes, public health monitoring, and biosurveillance.
- *To reduce costs associated with duplicative testing and administrative processes* – Providers and payers can quickly obtain the information necessary to process claims and deliver case management.
- *To actively engage patients in the management of their healthcare* – Through

personal health records, patients can utilize network resources for health monitoring and other e-clinical services such as online scheduling, clinician messaging, and access to educational materials.

- *To establish a best practices model for statewide replicability and participation* – The pilot project will demonstrate the effectiveness of HIE and offer valuable lessons learned for future expansion.

Due to the large percentage of Alaska Natives eligible for Medicaid, the State Medicaid Program has enlisted the Alaska Native Tribal Health Consortium (ANTHC) to assist with the planning and oversight of this project. ANTHC facilitated the creation of Alaska ChartLink, a group of healthcare leaders from around the state who possess extensive experience in the planning and oversight of many statewide telehealth projects.

Alaska's Uninsured

Staff of the Department of Health and Social Services, working on the State Planning Grant on insurance coverage funded by the US Department of Health and Human Services, Health Resources and Services Administration, (2005-2007), has assembled data from many sources that show that Alaska's highly seasonal employment patterns make it difficult for workers to qualify for consistent health care coverage. Focus groups conducted in 2006 and 2007 reported that those at risk of being uninsured expected to be responsible for contributing to the cost of health care coverage, but generally could afford about $100 a month, considerably less than the cost of a health insurance policy for an individual or family.
http://www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/default.htm

About 83 percent of Alaska residents are covered by health insurance (including government health coverage) at some time during the year.[1]The annual Current Population Survey indicates that employment-based health insurance accounts for coverage of more than half of Alaskans (52%), and public programs cover one third of Alaskans (Medicaid covers about 108,000, Military programs cover 84,000 people who are residents, Medicare covers nearly 56,000 Alaskans).

Young adults, especially males 18-24, are the most likely age-sex group to be uninsured. Part time and seasonal workers and the self-employed are also less likely than full-time workers to be insured. Although the majority of uninsured people are low-income, over a third are middle and higher income, and about half of the uninsured people are employed.

Smaller firms are less likely to offer health insurance than larger firms (according to state surveys of employers in 2001 and 2006, and US Medical Expenditure Panel Survey). Even the larger firms do not generally offer insurance to seasonal workers or to all part time employees.

Effects of Medicaid Rate Freeze

Providers of Developmental Disabilities and Senior Medicaid services have experienced significant cost increases related to fuel, health care, and worker's compensation in particular, as well as inflation in general. However, provider rates have been frozen since 2004. The rate freeze is impacting the financial stability of provider organizations as well as their workforce. Difficulties in recruiting and retaining quality staff in general are exacerbated by the freeze.

Emergency Preparedness

Individuals with special health care needs and disabilities are extremely vulnerable during and after an emergency or disaster. Particularly important are issues of notification, evacuation/transportation, sheltering, having access to power (i.e. for ventilators, electric wheelchairs, suctioning equipment, and refrigeration), medications, mobility equipment, and accessible information. For those who are technology dependent, being without power, durable medical equipment, medical supplies and pharmaceuticals can be life threatening. A flooded or damaged ramp may prevent evacuation of a building or home. Shelters may not be prepared for people who are deaf, people with mental illness, and those who cannot transfer onto a low-lying cot, or drink out of a cup without a straw.

Recent disasters in the Gulf Coast of the United States made evident to the American public that emergency response and recovery systems are inadequately equipped to accommodate people with disabilities and special health care needs. A national review of emergency preparedness plans in all U.S. states and 75 major U.S. cities found that none adequately addressed special needs populations. All levels of government would benefit from increased participation of people with disabilities and disability experts in the development and execution of emergency preparedness plans, training, and exercises.

Cross training among emergency and disaster preparedness professionals, organizations providing services to Trust beneficiaries, and advocates would be beneficial. Emergency responders need information about how to accommodate Trust beneficiaries, and Trust beneficiaries would benefit from learning how to be prepared for an emergency.

There have been some activities in Alaska to address emergency preparedness for special needs populations. For example, the Municipality of Anchorage started a Special Needs Registry. Also the Governor's Council on Disabilities and Special Education has included this topic in their five-year plan and will be bringing together partners to discuss next steps and increase dialogue among disability groups and emergency preparedness staff. The Department of Health and Social Services Public Health Preparedness Program is coordinating community-specific planning to address emergency preparedness throughout the state. They are providing guidance to local communities to prepare their community-specific plans. The Division of Behavioral Health is also assisting with disaster response in communities for responders as well as victims.

Emerging Addiction Research

New studies using brain imaging have confirmed that addiction is a treatable disease. Discoveries in the science of addiction have led to advances in drug and alcohol abuse treatments that help people stop abusing drugs and resume their productive lives. Alaska's drug and alcohol treatment system is not able to take full advantage of these advances because of lack of funding and provider shortages. This imposes significant long and short term costs on individuals and society.

Emphasis on Prevention and Intervention Services

Prevention of mental health problems, brain injury, Alzheimer's disease, and substance abuse includes building positive influences and protective factors into Alaskans' lives. Interventions can prevent behaviors from becoming more severe, relapse and secondary conditions. Early intervention can often keep children's emotional and developmental disorders from becoming more severe.

A growing prevalence of children with autism spectrum disorders has raised the urgency of need for early intensive intervention. Unique to this group of children is the possibility of ameliorating symptoms. Evidence-based interventions have been shown to substantially decrease the need for special education and lifelong care when averaged over the population of children with autism spectrum disorders. Alaska lacks strong intervention programs in autism, as well as a financing mechanism to pay for such services. The lifetime cost of care for a person with autism has been estimated at $3.2 million, yet early intensive intervention has been shown to decrease the lifetime cost of care by 75%. There is a need to develop and finance both an intervention program that is coordinated across service systems and a workforce to deliver the services.

Prevention and early intervention efforts are critical to minimize the financial and personal costs associated with Alzheimer's disease and related dementias (ADRD) in the future. With Alaska's senior population projected to grow at an unparalleled rate over the next 25 years, unprecedented demands will be placed on the state's long-term care system. A study of Medicaid costs by the Lewin Group (2006) projected that seniors' costs will begin to dominate Alaska's Medicaid program as the baby boomers age. Programs that encourage baby boomers and seniors to develop or maintain healthy lifestyle habits such as physical activity, good nutrition, regular socialization, and engagement in mentally challenging tasks will pay off in substantially lower health care and long-term care costs as well as greater well-being for seniors. Such programs can be implemented through workplaces, churches, senior centers, community organizations and many other partnerships.

Insurance for Behavioral Health Treatment

A national move to include behavioral treatment (mental health and substance use disorders) in health insurance coverage at the same level as physical health reflects the awareness that many physical health problems are tied to behavioral health problems. Senator Murkowski is cosponsoring the Mental Health Parity Act of 2007 on a national

level, but as Alaska looks at the structure of its funding for health care services, it is essential that we also look at the coverage available for behavioral health services in our state. Parity in behavioral health coverage has been shown to reduce both physical health care and societal costs.

Long-Term Care Strategic Plan

Alaska faces an enormous increase in the demand for long-term care as well as other services such as health care and affordable, appropriate housing. One of the recommendations of the Alaska Long Term Care and Cost Study (2006) was that the State of Alaska develop a three-to-five year statewide strategic plan for long-term care to ensure that it remains responsive to the needs of consumers, providers, and all other stakeholders. Such a plan would provide a blueprint with goals, strategies, and performance outcomes that can be used to guide the service system as it continues to grow and expand.

One factor driving the need for a strategic plan is the aging of the baby boomer generation. The number of seniors in Alaska is growing faster than any almost every other state's senior population. It is estimated that by 2030, Alaska will be home to more than twice as many seniors, including three times as many who are age 85 and older – the group most vulnerable to Alzheimer's disease and related dementias (ADRD).

Medicaid Issues

Several upcoming Medicaid issues could result in significant general fund expenditures for the State of Alaska.

Because of federal changes to the rates at which state governments and the federal government share Medicaid costs, Alaska's Medicaid costs could increase by more than $70 million per year beginning in federal fiscal year 2008. Due to intervention by Alaska's congressional delegation, the federal government will continue to pay Medicaid costs at a rate of 57 percent and Alaska will continue paying at 43 percent until federal FY 08. At that time, the federal government is projected to pay 51.76 percent and state government 48.24 percent; an increase of more than 5 percent for the state.

Federal deficit reduction measures in Medicaid and in other social services and education programs will shift costs to states. For example, Targeted Case Management, a service reimbursable by Medicaid and used by states for children in foster care and other federally mandated programs, now has stricter definitions that limit states' ability to bill for this service thus increasing state expense. We can anticipate further federal deficit reduction measures at the expense of states, such as regulations that narrowly define rehabilitative services and those that define public entities as only those with taxing authority which limits sources of available matching funds for Medicaid. In addition, stricter audit guidelines and closer financial scrutiny are driving unofficial federal policy changes that also shift costs to the state.

Alaska is projected to have a significant increase in the elderly population. The Lewin Group and ECONorthwest's February 15, 2006 report "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025" predicted substantial growth in spending on Alaska's Medicaid program, driven by a change from serving predominantly children to one dominated by seniors. The services needed by seniors, Home and Community-based Waiver Services, behavioral health, and personal care services, were identified as major cost drivers which will cause an increase to expenditures from the general fund.

The temporary increase in Medicare physician reimbursement for Alaska has lapsed, and the reduction in reimbursement has contributed to some physicians no longer accepting Medicare. Since Medicaid only pays after Medicare, health care access for those qualifying for both Medicaid and Medicare is impacted. In order to bring stability to this segment of the health care system, there needs to be a permanent federal adjustment made for Medicare reimbursement that reflects the significantly higher cost of providing health care in Alaska.

The Pacific Health Policy Group (PHPG) January 2007 report to Senate Finance offered several recommendations about Medicaid reform. The PHGP details inefficiencies in the Medicaid system that result in large general fund expenditures. It identifies approximately $220 million that is currently paid by Medicaid to non-tribal providers on behalf of American Indians and Alaska Natives. The PHGP report resulted in a $2.3 million Legislative appropriation for the Department of Health and Social Services to further define and implement the opportunities noted by the PHGP report on defining the future of Medicaid in Alaska.

Need for Accessible Information about Available Services

The boards and commission associated with The Trust report that Trust beneficiaries needing information about long-term care and other services often say they do not know where to turn. Seniors especially would like to speak to a "live" individual when they need information, rather than leaving phone messages and receiving a return call several days later suggesting additional numbers to call. The Aging and Disability Resource Centers (ADRCs) are moving toward becoming a "one-stop shop" for information about available programs, services, and benefits for seniors and people with disabilities. The ADRCs also plan to become part of Network of Care, a nationwide system to help consumers, their caregivers, and service providers locate specific services in their communities or regions via an interactive website and/or a toll-free phone number that is staffed around the clock.

ADRC's are a collaborative effort of the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services offered in Alaska through five regional offices of the Statewide Independent Living Council or SILC (in Anchorage/Mat-Su, Fairbanks, Juneau, Kotzebue, and Kenai) as information resources to help streamline access to long-term care.

Specialized Senior Behavioral Health Services

Senior services providers report a growing number of clients experiencing serious behavioral health needs. Aggressive behavior and substance abuse are becoming more common and more problematic in settings such as senior centers and independent-living senior housing. Pioneer Homes and assisted living facilities are seeing more seriously mentally ill (though previously undiagnosed) individuals, and report that they are not prepared to serve these clients in a general population setting. When behavioral health issues overlap with ADRD, treatment is particularly difficult to locate. Isolation, depression and grief issues are also common among older Alaskans. Seniors often refuse to seek help from sources such as a community mental health center or a local Alcoholics Anonymous meeting for fear of stigma. Special approaches are necessary to identify, make contact with, assess, and provide behavioral health services to seniors. In many communities, no programs are in place to meet these unique needs.

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Attachment C

Alaska Health Care Strategies Council, "Final Report: Summary and Recommendations;" online at
http://www.hss.state.ak.us/commissioner/legislature/pdf/HCSPC_report.pdf

Alaska Health Care Strategies Planning Council

Final Report: Summary and Recommendations

Making Alaskans the healthiest people in the nation...

December 23, 2007

Table of Contents

Executive Summary	1
The Council's Vision and Long-Term Goal	1
The "Fact-Based" Process	2
Alaska's Health Care Challenges: *A Strategic Plan for the Future*	2
Alaska's Health Care Action Plan	3
Alaska's Health Care Challenges: *Discussion and Recommendations*	4
Goal 1: *The High Cost of Health Care in Alaska*	4
Goal 2: *The Health Care Workforce*	5
Goal 3: *Sustainable Rural Water and Wastewater Systems*	5
Goal 4: *Access to Health Care*	6
Goal 5: *Prevention and Personal Responsibility*	7
Goal 6: *Statewide Leadership*	7
Goal 7: *Health Insurance*	8
Summary and Conclusions	9
Appendices	11

Executive Summary

On February 15, 2007, Governor Sarah Palin issued Administrative Order #232 establishing the Alaska Health Care Strategies Planning Council in the Office of the Governor. The purpose of the Council was to build the foundation for developing a statewide plan to identify both short-term and long-term strategies that effectively address issues related to access, cost and quality of health care for Alaskans. Members of the Council, all appointed by Governor Palin, are listed in Appendix C.

The Council interpreted its charge from Governor Palin broadly, to focus on the overall goal of improving the health of Alaskans. Within that broad charge, the Council considered health care to be an important component in improving the health of Alaskans. According to the Council, health care is a broadly defined term, relating to the prevention, treatment and management of illness, preserving mental, behavioral, physical health, and dealing with chemical dependency.

In accordance with the order, the Council reviewed and synthesized the extensive body of existing research on the subject, agreed upon the most salient facts, and identified the most significant health care issues in the state. Based on seven overarching healthcare challenges identified by the Council, members articulated the following seven comprehensive health care policy goals:

- *Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals;*
- *Health care costs for all Alaskans will consistently be below the national average;*
- *Alaska will have a sustainable health care workforce;*
- *All Alaskan communities will have access to clean and safe water and wastewater systems;*
- *Quality health care will be accessible to all Alaskans to meet their health care needs;*
- *Develop and foster the statewide leadership necessary to support a comprehensive statewide health care policy;*
- *Increase the number of Alaskans covered by health insurance and encourage employers to offer a range of health insurance options.*

Because of its short time frame, the Council was unable to address the Administrative Order's directive to present fiscal information to accompany each of the short- and long-term strategies. Unfortunately, with only 24 hours of face-to-face meeting time, identifying the fiscal impact of recommendations remains unaddressed, and must be a top priority in future consideration by this or subsequent bodies.

The Council's Vision and Long-term Goal

At its inaugural meeting on June 11, 2007, Council members articulated an overall vision of health care in Alaska – that "***Alaskans are the healthiest people in the nation.***" This vision led to development of a concrete mission statement describing the ultimate

outcome of the Council's work: "***To develop strategies, including performance measures, to provide health care access to all Alaskans by 2014.***"

The "Fact-Based Process"
The work of the Council was facilitated through a "fact-based" process by Mr. Dennis McMillian, President and CEO of The Foraker Group, an Alaskan-based nonprofit corporation. Members were asked to review existing research and initiatives, and hear from subject-matter experts on the major issues in Alaska's health care system. Only those facts garnered from existing sources and/or presented to the Council at its meetings, and which were widely recognized by Council member as salient to the process, were allowed to remain in the conversation.

While time-consuming, the fact-based process allowed the development of a solid basis for discussing the issue of health care in Alaska, highlighting the major challenges with that system, and identifying realistic solutions to address those challenges.

Alaska's Health Care Challenges: A Strategic Plan for the Future
In the opinion of the Council, there are seven challenges requiring immediate and comprehensive attention in Alaska's health care system:

- *Prevention and personal responsibility don't play big enough roles in the health and health care of Alaskans;*
- *Receiving quality health care in Alaska is expensive, well above the national average, and increasing;*
- *There are significant shortages in the health care workforce across the state;*
- *Water and wastewater systems in many rural communities lead to health problems;*
- *Quality health care is difficult to access for many Alaskans, urban and rural;*
- *There must be consistent and focused state and local leadership to improve the health of Alaskans, and build a comprehensive health care system in Alaska;*
- *Health insurance is an important if as yet misunderstood part of comprehensive health and health care.*

Based on the vision of a healthy Alaska, a one-page "Alaska Health Care Action Plan" was developed by the Council. The plan appears in the following section, and includes a combination of long-term and short-term goals. Where applicable, the short-term strategies appear at the beginning of the relevant goals.

During its work the Council was able to generate dozens of possible solutions to address the challenges, much of that the result of "brain-storming." The identified solutions are presented in Appendix A. Most require development of implementation plans, which was considered beyond the scope of the Council's work, especially given the short window for completion of its tasks. Although they are not developed fully, the articulated solutions in the plan, and within Appendix A, present a real and actionable foundation for helping to meet the goals in the "Alaska Health Care Action Plan."

Alaska's Health Care Action Plan: "*Making Alaskans the healthiest people in the nation.*"
Long-Term Goals and Strategic Directions (2008 – 2014)

Goal One: Health costs for all Alaskans will consistently be below the national average.

- Increase the place of consumerism in health care purchasing by giving people control over their health care dollar – the foundations are accessible, transparent, evidence based price/quality information about providers and services (short-term)
- Create an easily accessible and constantly updated website containing evidence-based price and quality information about health care providers and services (short-term)
- Increase community-based health care services, both public and private sector
- Stabilize the costs of health care by reducing the rate of increase relative to other states (national increase is 6%, decrease Alaskan rate to 4% annual increase)

Goal Two: Alaska will have a sustainable health care workforce.

- Increase WWAMI seats to 50 per year, and increase seats in UA Nursing and Nurse Practitioner programs (short-term)
- Develop policies and systems to alleviate the health care worker shortage, and prevent it from recurring
- Implement a doctoral-level nursing program at the University of Alaska to meet the 2015 deadline for Nurse Practitioner education requirements

Goal Three: All Alaskan communities will have clean and safe water and wastewater systems.

- Improve adherence to the state's existing water and wastewater treatment "plan," through the Village Safe Water Program

Goal Four: Quality health care will be accessible to all Alaskans to meet their health care needs.

- Expand tele-health and electronic health record systems, taking the lead in pursuing matching FCC grant funds (short-term)
- Increase presence of the public health system, particularly public health nurses, especially in rural communities (short-term)
- Increase access of Alaskans to a primary care provider and behavioral health provider when they are needed
- Decrease the likelihood that Alaskans will use emergency rooms for primary care
- Reduce the impact of existing barriers to health care accessibility by exploring private enterprise incentives
- Improve primary and long-term health care options for elders, particularly with regard to Medicaid and Medicare

Goal Five: Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals.

- Decrease the impact of obesity, smoking, substance abuse and other lifestyle factors on the health of Alaskans, through intense public education with public and private partners (short-term)
- Improve the likelihood that every Alaskan will choose to live a healthy lifestyle and make healthy lifestyle choices
- Increase the place of personal responsibility in health care decision making for all Alaskans

Goal Six: Develop and foster the statewide leadership necessary to develop and support a comprehensive statewide health and health care policy.

- Create an ongoing, quasi-independent, non-partisan, volunteer "Alaska Health Care Commission" in statute (short-term)
- Elevate the discussion of health care to a statewide audience

Goal Seven: Increase the number of Alaskans covered by health insurance

- Raise the eligibility criteria for Denali KidCare from the current 175% to 200% of federal poverty limits (short-term)
- Reduce potential for financial impact from catastrophic loss by supporting new and innovative approaches to insurance for individuals, which would be consumer-owned, portable, and purchased with pre-tax dollars
- All Alaskans have at least a catastrophic, incentive-based insurance option (i.e., high deductible coverage)
- Encourage employers, through varied incentives, to offer a range of insurance options/choices to employees – to include at a minimum, high deductible plans

Alaska's Health Care Challenges: Discussion and Recommendations
The Council engaged in lengthy discussion of the seven main challenges facing Alaska's health care system, and generated the following discussion points related to each.

- *Defining the specific problem or problems*
- *Why addressing them through comprehensive state action is important*
- *What should be done about it – in other words, identifying desired outcomes*

In addition to discussing what should be done to address each problem, the Council generated possible solutions and solicited public comment on the Health Care Action Plan. A Strategic Implementation Table (Appendix A) list the many solutions generated by the Council, and sets the foundation for implementation of selected short and long-term strategies. The full text of public comment will be presented to Governor Palin under separate cover, but the overriding themes contained within those comments are summarized in Appendix B.

Goal One: The High Cost of Health Care in Alaska

What's the problem? *The costs of producing quality health care are high, and therefore it is quite expensive to be a consumer of that care. The costs of health care in Alaska are already well above the national average, and like the rest of the nation, are increasing.*

Why this is important: *A new approach to this problem must be embraced if there is to be long-term, positive reform in Alaska's health care system. If Alaska continues along the same path, the results will remain unchanged. Reducing the rate of increase in the costs of health care is a "must do" priority, and Alaskans need to get the best value for health care dollars spent. Every health care dollar must be spent wisely. Broadly stated, the high cost of health care is a barrier to many Alaskans getting the health care they need. The present system supports the high and increasing costs of health care and inefficient utilization of health care dollars.*

What should be done about it: *Decreasing the rate of growth in health care costs in Alaska will require development of a high-quality health care system that is evidence-based, consumer driven and market-responsive. With respect to lowering costs, insurance that is portable and consumer-owned plays a central role, and requires much more discussion at the state level. Overall, giving people more control over their health care dollar is a central component, as is providing appropriate, accessible, transparent, and evidence-based cost and quality information about health care providers and services. In the short-term, one of the most important goals should be state creation of an easily accessible and up-to-date website providing health care cost and quality information to Alaskans. These strategies alone are not sufficient to reduce the overall cost of health care in Alaska, nor to reduce the rate of growth. Closely related are the subjects of personal responsibility, access to health care, increasing the number of health care providers, and insurance.*

Goal Two: The Health Care Workforce

What's the problem? *There are significant shortages in the health care workforce across the state. Alaska needs more health care workers throughout the system, at all levels.*

Why this is important: *Without ample health care workers, the system will continue to falter – it is already showing signs of strain. Lack of a sustainable health care workforce is a primary factor in the increasing costs of health care, and also in the decreasing access of health care for Alaskans. In addition, significant access issues exist in both urban and rural areas, which will likely require expansion of the health care workforce.*

What should be done: *Statewide policy should enable the creation of a sustainable health care workforce that alleviates the current shortage and prevents it from recurring. A good start is to "grow more of our own" within Alaska, by presenting health care professions more prominently as viable career options, with students continually encouraged to build the skills and the interests necessary to pursue health care careers. In the short-term, to increase primary care providers in the state, the number of WWAMI seats should be increased to meet the projected need of 50 per year in the next decade. In concert with that, the University of Alaska nursing doctorate degree should be implemented as well. The number of resident positions in the Family Practice Residency Program should be increased, as should the number of graduates in both the UA Nursing and Nurse Practitioner Programs.*

Goal Three: Sustainable Rural Water and Wastewater Systems

What's the problem: *Water and wastewater systems in many rural communities are inadequate, unsafe, or non-existent, and can be a major cause of health problems within those communities.*

Why this is important: *There is a strong correlation between the health of Alaska's rural residents, and water and wastewater safety. Building and operating clean drinking water and wastewater disposal systems is one of the most effective means for improving the health and wellness of rural Alaskans and rural communities.*

What should be done: *There is an active state program in place to bring sustainable and safe drinking water and wastewater disposal systems to all of Alaska's rural communities – the Village Safe Water Program. However, the real success of that program depends on the recognition by state policy makers that there is no "one" size fits all" approach to bringing those systems to rural Alaska. What works in one community may not work in another. Efforts to provide infrastructure that the community can support in the future should continue. The state's long-term health care policy, therefore, should improve and ensure the state's adherence to the "plan" for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community.*

Goal Four: Access to Health Care

What's the problem? *Accessing quality health care is difficult for many Alaskans, both urban and rural. There is little consistency of access to health care for all Alaskans – some have it all the time, some have it some times, and some have it hardly at all. In Alaska's urban areas there is a lack of access to necessary specialized care and efficient "same-day" primary care. In rural communities, there is often no access at all to health care because of a variety of barriers, including costs, geography, transportation challenges, lack of providers and much more.*

Why this is important? *The lack of access to quality health care contributes to Alaskans' wellness challenges. Being able to guarantee timely access to primary care, in particular, presents significant challenges; but appropriate primary care is one of the most effective means for keeping Alaskans healthy. There was considerable discussion among members about the positive impact of Community Health Centers, and the state's public health nurses, in providing greater access to health and health care opportunities*

There was agreement among Council members on two major points relevant to health care access. First, Community Health Centers (CHCs) are a valuable part of the "health care safety net" for Alaskans. Second, the state's public health nursing structure is one of the most important mechanisms for affording greater access to a wider range of health care. The problem with CHCs and public health nursing is that both programs are under-funded. Community Health Centers are federally funded, and most states provide supplemental financial assistance because CHCs are viewed as an important part of the overall health care system in those states. Partly due to the provision of health care services to the under-insured and uninsured, CHCs consistently face budgetary challenges. In Alaska CHCs receive virtually no funding from the state. Similarly, the state's public health nursing system has been chronically under-funded for years. Ever-decreasing state dollars for the Public Health Division has meant that fewer and fewer public health nurses are able to do their important work improving the health of Alaskans.

What should be done: *Accessing health care should not be difficult for Alaskans, and broad policies that improve access to primary care and behavioral health care should be the focus of any state health care policy. Strategies should include: 1) the state becoming more actively engaged as an active investor in the Community Health Center system through supplemental funding and regulatory relief; 2) appropriate funding for and utilization of the state's Public Health Division, in particular the Public Health Nursing program, 3) building monetary and other incentives into the health care system which encourage Alaskans to more effectively utilize primary care opportunities; 4) leveraging information technologies such as tele-health and electronic health record systems which can improve access while reducing costs; and 5) reducing barriers to private clinicians practicing in underserved areas. In the very short term, the state could take the lead in guaranteeing that the required "match" associated with the current $10 million Federal Communications Commission tele-health grant is made.*

Goal Five: Prevention and Personal Responsibility

What's the problem: *Prevention and personal responsibility play too small a role in health care, including maintaining and improving health. While Alaskans may understand the connection between their lifestyle choices and their individual health, for the most part they do not make a connection between personal choices, having a personal stake in their health, and the cost of their health care. Alaskans are not optimally encouraged and equipped to make the kinds of choices that improve health and subsequently decrease health care costs.*

Why this is important: *More healthy Alaskans translates into fewer sick Alaskans, and improved quality of life with resultant cost savings. A clear understanding of the role of personal choice in individual health status and the impact on health care costs, as well as the central role of government in supporting health choices, are critical components in developing long-term strategic health and health care policies.*

What should be done about it: *Solving this problem requires a two-pronged approach. First, Alaskans must be encouraged to play a much greater role in their own wellness by having both a personal and financial "stake" in their own health. Having a "stake" in their own health is the product of a personal investment in wellness, and realizing the financial benefits of saved dollars by maintaining healthy lifestyles. In the opinion of the Council, the most effective mechanism for increasing the personal health investment of Alaskans is incentivizing and supporting positive change.*

Second, governments, school districts, tribal entities and other employers are uniquely situated to be catalysts for positive change. These entities have the influence to help Alaskans understand and make healthy choices, while at the same time avoiding those lifestyle decisions that contribute to poor health.

Goal Six: Statewide Leadership

What's the problem: *A lack of consistent statewide leadership makes development of comprehensive statewide health and health care policy challenging.*

Why this is important: *Public leaders have a pivotal role as catalysts for positive change. Commitment at the executive and legislative levels to comprehensive and lasting change will effect health and health care in Alaska.*

What should be done about it: *The Council believes that government has an obligation to "jump start" healthy choices through incentives, and in addition build the necessary incentive structures for the future. Positive change will be the result of a concerted effort by the governor and the legislature, through partnering with local communities, in a long-term commitment to maintain positive momentum. The key is elevating the discussion of health and health care to the statewide level.*

One of the most effective mechanisms for solidifying that long-term commitment to bringing positive change to Alaska's health care system is to establish through statute a quasi-independent "Alaska Health Care Commission," which would seek to provide advice on innovative solutions, and act as a catalyst for positive change. The Commission would be responsible for advising state leaders on incentivizing positive lifestyle choices; fostering ongoing research; controlling health care costs; improving access, and ensuring a sustainable health care workforce.

Goal Seven: Health Insurance

What's the problem: *Over 100,000 Alaskans – including more than 14,000 children – are without health insurance at some time during any given year. When insurance is made available, there is often a misconception that it should cover everything, from routine and predictable events to catastrophic occurrences and long-term care; this misconception increases the cost of health insurance beyond the reach of many Alaskans.*

Why this is important: *Having access to health insurance coverage is one of the most significant determinants of access to appropriate health care. Alaskans who do not have health insurance are often unable to get the services they need to become healthy, and to maintain wellness.*

When uninsured Alaskans do seek health and health care services, it is often for expensive chronic conditions which could possibly have been avoided if they had had health insurance coverage, or access to appropriate primary care. When Alaskans who may not be eligible for Medicaid and Denali KidCare do access health care, they are often unable to pay and often seek care in a hospital emergency room, which is the most expensive and inefficient mechanism for receiving primary care. The costs of such access are borne across the whole health care system, which raises the overall costs of health care in Alaska. When the uninsured who are not eligible for Medicaid and Denali KidCare do pay for health and health care services, they often do so at significant personal and family financial impact.

Not having insurance is only part of the problem, and simply providing insurance under the current structure is not the answer. With the exception of preventative health services, comprehensive health insurance is not an efficient way to pay for routine and predictable care, such as the common cold, ear infections, hang nails, and sprained ankles. Whereas health insurance IS the most important tool for protecting people from unplanned catastrophic health events, it is an inefficient way to pay for routine expenditures. Therefore, the current system, which relies on insurance to pay for routine and predictable health care expenses, raises the costs of premiums above the reach of many Alaskans.

What should be done about it: *More Alaskans need to be covered by efficient health insurance plans. Increasing the number of Alaskans covered by efficient health insurance will be the result of several specific actions. In the short-term, the Council recommends that the state immediately pursue and support change in the Denali KidCare program to make Alaskan children in families at 200% of the federal poverty level eligible for coverage. While there was a majority vote among Council members regarding this expansion of Denali KidCare coverage, the role of that program within an efficient and effective system of health care coverage is worthy of continued debate at the statewide level, through the recommended "Alaska Health Care Commission."*

To most effectively cover the adults and remaining children without health insurance, bringing consumerism to the forefront of Alaska's health insurance structure is important. Alaskans should have access to choices, through a wide range of health insurance options, including at the very least high deductible coverage with a strong prevention component. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. Whereas some uninsured Alaskans are not working, most are working for employers who would like to, but cannot necessarily afford to, provide health insurance coverage for their employees. Therefore, through incentives, Alaskan employers should be encouraged to offer a wide range of coverage choices, to include at a minimum, high deductible coverage

Consumerism is an essential component of bringing rationality to the health insurance structure in Alaska, and extending coverage to as many Alaskans as possible. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. In addition, insurance must be consumer-owned, market-responsive and portable; this recommendation has received attention elsewhere in this report. Coverage options debated in the Council's discussions, which are by no means exhaustive, include Health Savings Accounts, Health Opportunity Accounts, and high-deductible plans with a strong prevention component. This list provides a solid foundation from which to continue the ongoing discussion about expanding health care coverage for all Alaskans.

Summary and Conclusions

Resolving the health and health care issues in Alaska will not be the result of a single solution. Instead, bringing real and lasting change means working together in partnership. Many of the solutions presented within this report fall squarely within the purview of state government. But no matter how committed state government is, solutions will not be forthcoming without involving all stakeholders as partners for change – from individual Alaskans to families, nonprofit organizations and private sector employers and employees, communities and local governments, tribal entities, state government, the governor, the legislature, and the federal government.

The Council has deliberately not prioritized solutions for solving the problems it has identified with the health and health care system in Alaska. Indeed, all of the problems must be addressed concurrently if real, long-term change is to take place. Having said that, within those identified by the Council, one is definitely the larger-order problem, meaning if we can solve it, many of the other problems will be alleviated. That problem is the lack of prevention and personal responsibility.

By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced. Most Alaskans will have both the motivation and the means to maintain their own wellness. And with greater wellness, the composition of the health care workforce will likely change, decreasing the dependence on health care professionals who are the most difficult and most expensive to attract and retain.

Becoming the healthiest people in the nation is indeed a grand vision – but it is real and achievable.

Respectfully Submitted,

The Alaska Health Care Strategies Planning Council
December 23, 2007

Appendix A: Strategy Implementation Table

2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014

Short-Term Strategies *(for implementation between 2008 and 2010)*	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline

• Pay the tuition – or forgive student loans – for residents from rural Alaska who are willing to practice – after graduation – in their home community.			
• Institute student loan forgiveness for medical/health professionals and para-professionals who make a commitment to stay in Alaska.			
• Provide grants for low-income vocational/tech students in Certified Nurses Assistant/Pharmacy Tech programs.			
• Increase the presence of public health system, particularly public health nurses, especially in rural communities.			
• Follow through on existing state plans for safe drinking water and wastewater, through the Village Safe Water Program and other efforts.			
• Support and expand telemedicine and tele-behavioral medicine – include education, maintenance and equipment upgrades.			
• Increase behavioral health training and support.			
• Increase available slots in Physician Assistant and Nurse Practitioner programs at the University of Alaska and with other academic partners.			
• Increase number of Residents in Family Practice Residency Program.			
• Create a greater awareness of the distinction between routine and predictable health care costs (less expensive) and unanticipated or catastrophic costs (more expensive).			
• Promote Health Savings Accounts and high deductible insurance plans – for individuals and employers.			
• Provide incentives for providers and consumers, with performance measures and rewards (for providers), based on evidence-based results.			
• Foster better informed consumers through creation of a dynamic (continuously updated) website providing transparent quality and cost information about medical services, prescriptions, etc.			
• Build teaching capacity in K-12 schools to excite young Alaskans about the physical sciences generally, and the health care field in particular.			
• Increase penalties for selling alcohol to youth.			

Long-Term Strategies ***(for implementation between 2010 - 2014)***	**Action Required** (Policy, Regulation, Statute)	**Expense**	**Implementation Timeline**
• Support information technology improvements.			
• Promote insurance that is portable, consumer-focused and consumer owned, purchased with pre-tax dollars.			
• Increase Alaska WWAMI seats to 50 /year – the projected need to meet demand in the next 10 years.			
• Institute doctoral NP program at UAA.			
• Increase the availability of education programs for health care disciplines.			

[redacted]

Appendix B: Summary of Public Comment Received by the Council

- Support the Community Health Centers as a way to improve access and decrease use of the emergency room for primary care.
- Improve e-health
- Increase workforce, specifically mid-level practitioners
- Incorporate incentives to attract and retain necessary health care workers, including loan forgiveness and other repayment incentives
- Make sure to get the mix right of what is needed in the health care workforce
- Recruitment programs are best done in state
- Build interest in the health care field at the middle and high school level
- Develop a statewide group with oversight responsibility for recruitment and retention – because it cost too much for individual organizations to do it
- Eliminate shortage of UA educators in health care professions
- Put fluoride in rural water systems
- Improve the place of preventative dental service in the health care continuum
- Prevention, collaboration and partnerships are the key to improving access
- Building existing programs makes the most sense, versus making new programs and the associated structures
- Remove bureaucratic barriers to effective health care access
- Examine innovative solutions that involve Medicaid reimbursement
- Acknowledge and build upon the work of public health nurses and the public health nursing program
- Include alternative treatments when talking about prevention and personal responsibility
- Improve worksite health as a cost-saver
- Most feel there should be basic, portable insurance coverage for all Alaskans
- Concentrate on preventing sickness rather than curing it
- Should be at least some mechanism to insure a minimum coverage for all Alaskans
- People with disabilities have real trouble finding primary care – the state should close the gap in those services
- Alaskans need a range of services that are affordable – maybe the state should subsidize those services
    - Don't forget the severely disadvantaged – Alaska's working poor
- Funding for substance abuse and mental health are effective preventative services, which lead to increase wellness
- State must support the e-health FCC grant
- State should not be shy about supplementing the loss of federal Medicaid dollars with state support
- Behavioral health in Alaska has taken huge cuts, and the system is on the verge of crisis
- The broadly stated goals of the Council really skip over the importance of behavioral health and substance abuse as preventative factors

- Oral health needs to play a more significant role in overall health
- Need more dental techs in the health care workforce
- Realize that turning 65 in Alaska means no more health care for most elders
- Make it easy for people to navigate the health care system – now it is really difficult
- Remove barriers that prevent Alaskans from receiving necessary primary care, and to get Denali KidCare after birth
- There MUST be a continued forum for addressing health care issues in the long term

Appendix C: Alaska Health Policy Council Members

The council is composed of 14 Alaskans appointed by the governor:

- Jeff Davis of Anchorage has served as president of Premera Blue Cross Blue Shield of Alaska for nine years, which provides insurance for 180,000 Alaskans statewide.
- Cathy Giessel of Anchorage is a registered nurse and advanced nurse practitioner whose career and experience spans more than 30 years.
- Dr. Derek Hagen of Anchorage is a doctor of osteopathy associated with Primary Care Associates, the largest private family practice in the state.
- Thomas Hendrix, PhD, of Anchorage is an assistant professor at the University of Alaska School of Nursing specializing in the policy, economics, assessment, and fundamentals of health care.
- Don Kashevaroff of Anchorage is the chair and president of the Alaska Native Tribal Health Consortium, and serves as the primary spokesman for the Consortium regarding state and federal funding, legislation, and regulatory issues.
- Brian Slocum of Fairbanks is the administrator at Tanana Valley Clinic, the largest multi-specialty, multi-site practice in Alaska.
- Dr. Michael Carroll of Fairbanks is a private practice physician, specializing in internal medicine and oncology.
- Donna Fenske of Homer served the State of Alaska as a public health nurse from 1979 to 2004 and most recently has provided community health aide services in Port Graham and Nanwalek clinics, and nursing services to K-12 students in rural communities in the Kenai Peninsula Borough School District.
- Steve Horn of Soldotna is the executive director of the Alaska Behavioral Health Association whose members are the businesses that provide direct services to recipients of behavioral health services throughout the state.
- Dr. Cathy Baldwin-Johnson of Wasilla is a private practice family physician and the 2002 National Family Physician of the Year from the American Academy of Family Physicians.
- Karen Rhoades of Wasilla is the owner and operator of Northern Living Centers, a five bed assisted-living home.
- Tim Joyce of Cordova is a three-term mayor of the City of Cordova who has dealt with escalating community medical costs, a constant turnover of medical center administrators and a community medical center that is continually in need of city assistance.
- Rod Betit of Juneau is the president and CEO of the Alaska State Hospital and Nursing Home Association (ASHNA), a not-for-profit association with members representing hospitals, nursing homes, and Native Alaska health care providers.
- Dr. Bob Urata of Juneau has served as a family physician for over 23 years, and has served on the Bartlett Regional Hospital Board of Directors.
- Commissioner Karleen Jackson managed the Health Council. Serving as ex-officio, non-voting members were Senator Bettye Davis and Representative Peggy Wilson, chairs of the Health, Education and Social Services committees in the Alaska State Legislature.

Attachment D

Turning Point, "Transforming Public Health State by State" and "States of Change: Stories of Transformation in Public Health;" available online at *http://www.turningpointprogram.org/Pages/archives.html*

Turning Point

Collaborating for a New Century in Public Health

Transforming Public Health State by State

Produced by the Turning Point National Program Office at the University of Washington.

Acknowledgments

The Turning Point National Program Office gratefully acknowledges the enthusiasm of the Turning Point state partnerships in the creation of these fact sheets and the accomplishments they describe. Expertise provided by staff from Radiant Communications and the RWJF's CONNECT project was also invaluable in supporting the development of these fact sheets.

Funding from The Robert Wood Johnson Foundation supports the efforts of the Turning Point National Program Office and the state partnerships.